FY 1998-99
COST REPORT

ENCLOSURE LISTING - COUNTIES

Enclosure Number	Type of Document	NNA Only Counties	NNA & DMC Counties	Filename on Diskette
FY 1998-99 CERTIFICATION FORMS				
Enclosure A	County Certification form (ADP I7885)	X	X	N/A
FY 1998-99 COUNTY WORKSHEETS				
Enclosure C	County Worksheets (ADP 7885 through ADP 7885K) with Instructions [REVISED]	X	X	89-7885, 89-7885A-I, 89-7885K
FY 1998-99 FUNDING DESCRIPTIONS				
Enclosure D	Funding Descriptions [REVISED]	X	X	N/A
FY 1998-99 SERVICE CODE LISTING				
Enclosure E	Service Code Listing	X	X	N/A
FY 1998-99 DATA ENTRY DISKETTE INSTRUCTIONS				
Enclosure F	FY 1998-99 Data Entry Diskette Instructions [NEW]	X	X	N/A
FY 1998-99 SERVICE CODE/PROGRAM CODE/FUNDING LINE LISTING				
Enclosure G	FY 1998-99 Service Code/Program Code/Funding Line Listing [NEW]	X	X	N/A
FY 1998-99 DMC FORMS				
Enclosure H	DMC Fiscal Detail – Report of Expenditures and Revenues (ADP Form 7895) with Instructions		X	89-7895Formula
Enclosure I	DMC Fiscal Detail – Report of Expenditures and Revenues (ADP Form 7895M) with Instructions		X	7895Mformula
Enclosure J	FY 1998-99 Cost Report Funding Application Worksheet – ODF Group (Form ODFGFUND) with Instructions [REVISED]		X	ODFGFUND
Enclosure K	FY 1998-99 Cost Report Funding Application Worksheet – ODF Individual (Form ODFIFUND) with Instructions [REVISED]		X	ODFIFUND
Enclosure L	FY 1998-99 Cost Report Funding Application Worksheet – DCH (Form DCHFUND) with Instructions [REVISED]		X	DCHFUND
Enclosure M	FY 1998-99 Cost Report Funding Application Worksheet – SAMPLE A and B		X	N/A
Enclosure N	DMC Fiscal Detail – DMC Program Cost Summary (ADP 7990) with Instructions [REVISED]		X	89-7990Formula
Enclosure O	Medi-Cal Outpatient Drug Free (ODF) Fiscal Model (Form ODFHR) AND Medi-Cal Outpatient Drug Free Fiscal Model (PODFHR) – HOURS with Instructions		X	89-Hours & 89Hourspn
Enclosure P	Medi-Cal Outpatient Drug Free (ODF) Fiscal Model (Form ODFAVG) AND Medi-Cal Outpatient Drug Free Fiscal Model (PODFAVGP) – AVERAGE with Instructions		X	89-Average & 89Averagepn
Enclosure Q	DMC Fiscal Detail – NTP – DMC Program Cost Summary - County Contract Submission – Alcohol and Drug Services (ADP 7990NAC) with Instructions		X	7990NAC

Enclosure R	DMC Fiscal Detail – NTP – DMC Program Cost Summary – County Contract Submission – Perinatal Services (ADP 7990NPC) with Instructions		X	7990NPC
FY 1998-99 MISCELLANEOUS DOCUMENTS				
Enclosure W	Submission of Cost Report Documents – Counties [REVISED]	X	X	N/A
Enclosure Y	Final DMC Rates for FY 1998-99		X	N/A
Enclosure Z	Checklist – FY 1998-99 Cost Report	X	X	N/A
Enclosure AA	Service Code Comparison – FY 1997-98 and FY 1998-99	X	X	N/A
Enclosure AB	Program Code Comparison – FY 1997-98 and FY 1998-99 [REVISED]	X	X	N/A
Enclosure AC	Funding Line Comparison – FY 1997-98 and FY 1998-99	X	X	N/A
Enclosure AD	FY 1998-99 Final Statewide Allocation [REVISED]	X	X	N/A
Enclosure AE	Instructions on How to Read your Remittance Advice (STD 404)	X	X	N/A
Enclosure AF	Computer Specifications	X	X	N/A
Enclosure AG	Fiscal Management Branch Assignment Listing [REVISED]	X	X	N/A
Enclosure AH	ADP Bulletin #98-42, dated August 17, 1998 (Fiscal/Audit Questions and Answers)	X	X	N/A
Enclosure AI	ADP Bulletin #99-17, dated May 20, 1999 (Update to Audit Assistance Guide)	X	X	N/A
Enclosure AJ	Department of Alcohol and Drug Programs – Acronym List	X	X	N/A
Enclosure AK	ADP Telephone Directory [NEW]	X	X	N/A
Enclosure AL	DSS Bulletin #98/99-03 dated September 16, 1998 regarding CalWORKs [NEW]	X	X	N/A
Enclosure AM	Follow-Up Issues Identified in FY 1998-99 Cost Report Training Sessions [NEW]	X	X	N/A

NOTE: The enclosures identified on this list ONLY pertain to counties.

Some documents were revised based on discussions held at the cost report training session and some documents are new that were not part of the original package that was issued in the cost report training sessions. Those documents are identified with either [REVISED] or [NEW].

Filename: G:\GROUPS3\FM\COST8-9\Enclosure Listing - Counties.doc (8/99)

_____ (County Name)

COUNTY CERTIFICATION

Prevention and Treatment Cost Report
Year-End Claim for Reimbursement
Fiscal Year 1998-99

I HEREBY CERTIFY *under penalty of perjury that I am the official responsible for the administration of Alcohol and Drug Program services in and for said claimant; that I have not violated any of the provisions of Section 1090 through 1096 of the California Government Code; that the amount for which reimbursement is claimed herein is in accordance with Division 10.5, Part 2, Chapter 4, and Division 10.5, Part 3, Chapter 4 of the California Health and Safety Code; and that to the best of my knowledge and belief this claim is in all respects true, correct, and in accordance with law.*

DATE: _____ SIGNATURE: _____
County Alcohol and Drug Program Administrator

EXECUTED AT _____, CALIFORNIA

I CERTIFY *under penalty of perjury, that I am the duly qualified and authorized official of the herein claimant responsible for the examination and settlement of accounts.*

DATE: _____ SIGNATURE: _____

TITLE: _____
County Auditor-Controller, City Finance Officer, etc.

EXECUTED AT _____, CALIFORNIA

FOR STATE USE ONLY

	State General	**Medi-Cal Federal**	**SAPT Block Grant**	**S.D.F.S.C.**
1. CLAIM FOR REIMBURSEMENT	_____	_____	_____	_____
2. ADVANCES PAID TO DATE	_____	_____	_____	_____
3. SPECIAL ADJUSTMENTS				
(A) AUDIT ADJUSTMENTS	_____	_____	_____	_____
(B) OTHER	_____	_____	_____	_____
4. NET REIMBURSEMENT	_____	_____	_____	_____

DATE: _____ SIGNATURE: _____
DEPARTMENT OF ALCOHOL & DRUG PROGRAMS

ADP I7885 (Revised 7/99)

DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS

COUNTY PREVENTION AND TREATMENT PROGRAMS COST REPORT

YEAR-END CLAIM FOR REIMBURSEMENT

FISCAL YEAR 1998-99

This form is to be used as a worksheet in completing the pre-programmed diskette.

It is not to be submitted as part of the Cost Report package.

		A	B	C	D	E	
LINE #	FUNDING SOURCES INCLUDING FED CAT #	TOTALS	STATE GENERAL	MEDI-CAL FEDERAL SHARE	SAPT BLOCK GRANT Fed Cat #93.959	S.D.F.S.C. Fed Cat #84.186	LINE #
40	Drug Medi-Cal (Federal Share Only) - Fed Cat #93.778	0					40
40a	Perinatal - Medi-Cal (Federal Share Only) - Fed Cat #93.778	0					40a
40b	Perinatal (PTEP) Match to Medi-Cal	0					40b
41c	Perinatal State General Funds (PSGF)	0					41c
41g	Perinatal Treatment Network Services SGF	0					41g
41h	Perinatal Substance Abuse Treatment SGF	0					41h
41x	Perinatal State General Funds - Backfill	0					41x
45	Female Offender Tx Proj - Fed Cat #93.959	0					45
46	Parolee Services Network (BASN, PPNP, PPP)	0					46
50	SAPT - Discretionary - Fed Cat #93.959	0					50
50a	Adolescent Treatment Services - Fed Cat #93.959	0					50a
51	HIV Set-Aside - Fed Cat #93.959	0					51
52	SAPT - Perinatal S/A - Fed Cat #93.959	0					52
56	SAPT Special Projects Summary of Funds - Fed Cat #93.959	0					56
56a	SAPT Discretionary One-Time - Fed Cat #93.959	0					56a
56b	SAPT Drug Courts - Fed Cat #93.959	0					56b
57	SSI/DA/A Funds - Fed Cat #93.959	0					57
57a	SSI/DA/A HIV Funds - Fed Cat #93.959	0					57a
58	DSS/CalWORKs SAPT						58a
58a	Private Industries Council						58a
62	SDFSC-School Based Prev. - Fed Cat #84.186	0					62
66	SDFSC-Friday Night Live - Fed Cat #84.186	0					66
68	SDFSC-Club Live - Fed Cat #84.186	0					68
68a	CA Mentor Initiative - Fed Cat # 84.186	0					68a
70	State General Fund - Match to Medi-Cal	0					70
79	TCM/MAA						79
80	Non-County Revenue						80
80c	State General Fund	0					80c
80e	DSS/CalWORKs - State General Fund						80e
80x	State General Fund - Backfill	0					80x
81c	Required County Match to Regular Alcohol/Drug or Perinatal						81c
82	County Funds - Other						82
82a	Provider Unrestricted Funds						82a
82b	County Unrestricted Funds						82b
83	Excess Fees Spent						83
84	Fees						84
85	Insurance						85
86	PC 1463.25 - SB 920 // HS 11372.7 - SB 921						86
87	PC 1463.16 - Statham						87
87c	Statham - Match to Regular Alcohol/Drug or Perinatal						87c
88	Excess DUI Profit / Surplus Spent						88
89	Driving Under Influence Fees & Admin. & Monitoring						89
89a	Penal Code (PC) 1000 Admin. Fees						89a
90a	Obligated Unexpended State Gen. Funds - Prior FY						90a
91	TOTAL FUNDING	0					91
100	**TOTAL CLAIMED**	0	0	0	0	0	100

INSTRUCTIONS: Enter in Column A on lines 40 through 90a, total amounts reported from corresponding lines on Summary Report ADP 7885B. Enter amounts claimed on appropriate lines in columns B through E.

DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS

COUNTY PREVENTION AND TREATMENT PROGRAMS COST REPORT

SUMMARY

FISCAL YEAR 1998-99

This form is to be used as a worksheet in completing the preprogrammed diskette. It is not to be submitted as part of the Cost Report package.

LINE #	FUNDING SOURCES INCLUDING FED CAT #	A SUPPORT SERVICES ACTUAL COST	B PRIMARY PREVENTION ACTUAL COST	C SECONDARY PREVENTION ACTUAL COST	D NONRESIDENTIAL SERVICES ACTUAL COST	E NARCOTIC TRMT. SRVS. ACTUAL COST	F PAGE TOTAL ACTUAL COST BY FUNDING SOURCE	LINE #
40	Drug/Medi - Cal (Federal Share Only) - Fed Cat #93.778						0	40
40a	Perinatal - Medi-Cal (Federal Share Only) - Fed Cat #93.778						0	40a
40b	Perinatal (PTEP) Match to Medi-Cal						0	40b
41c	Perinatal State General Funds (PSGF)						0	41c
41g	Perinatal Treatment Network Services SGF						0	41g
41h	Perinatal Substance Abuse Treatment SGF						0	41h
41x	Perinatal State General Funds - Backfill						0	41x
45	Female Offender Tx. Proj. - Fed Cat #93.959							45
46	Parolee Services Projects (BASN, PPNP, PPP)						0	46
50	SAPT - Discretionary - Fed Cat. #93.959						0	50
50a	Adolescent Treatment Services - Fed Cat #93.959						0	50a
51	HIV Set-Aside - Fed Cat. #93.959						0	51
52	SAPT - Perinatal S/A - Fed. Cat #93.959						0	52
56	SAPT Special Projects Summary of Funds						0	56
56a	SAPT Discretionary One-Time - Fed Cat # 93-959						0	56a
56b	SAPT Drug Courts - Fed Cat #93.959						0	56b
57	SSI/DA/A Funds - Fed Cat #93.959						0	57
57a	SSI/DA/A HIV Funds - Fed Cat #93.959							57a
58	DSS/CalWORKSs SAPT						0	58
58a	Private Industries Council						0	58a
62	SDFSC-Community Based Prev - Fed Cat # 84.186						0	62
66	SDFSC-Friday Night Live - Fed Cat #84.186						0	66
68	SDFSC-Club Live - Fed Cat #84.186						0	68
68a	Ca. Mentor Initiative - Fed Cat # 84.186						0	68a
70	State General Fund - Match to Medi-Cal						0	70
79	TCM/MAA						0	79
80	Non-County Revenue						0	80
80c	State General Fund						0	80c
80e	DSS/CalWORKs - State General Funds						0	80e
80x	State General Funds - Backfill						0	80x
81c	Required County Match (Alcohol/Drug or Perinatal)						0	81c
82	County Funds - Other						0	82
82a	Provider Unrestricted Funds						0	82a
82b	County Unrestricted Funds						0	82b
83	Excess Fees Spent						0	83
84	Fees						0	84
85	Insurance						0	85
86	PC 1463.25 - SB 920 // HS 11372.7 - SB 921						0	86
87	PC 1463.16 - Statham						0	87
87c	Statham Match (Alcohol/Drug or Perinatal)						0	87c
88	Excess DUI Profit/Surplus						0	88
89	Driving Under Influence - Fees/Admin. & Monitoring						0	89
89a	Penal Code 1000 (Admin. Fees)						0	89a
90a	Obligated Unexpended State General Funds - Prior FY						0	90a
91	TOTAL FUNDING BY SERVICE CATEGORY	0	0	0	0	0	0	91
93	Excess Fees Carry-over						0	93
94	TOTAL ALCOHOL COSTS - Fed Cat #93.959						0	94
96	TOTAL DRUG COSTS - Fed Cat #93.959						0	96
99	D/MC County Administration						0	99

ADP 7885A (Rev. 7/99)

DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS
COUNTY PREVENTION AND TREATMENT PROGRAMS COST REPORT
SUMMARY
FISCAL YEAR 1998-99

This form is to be used as a worksheet in completing the pre-programmed diskette. It is not to be submitted as part of the Cost Report package.

LINE #	FUNDING SOURCES INCLUDING FED CAT #	G RESIDENTIAL SERVICES ACTUAL COST	H ANCILLARY SERVICES ACTUAL COST	I DRIVING UNDER INFLUENCE PROG ACTUAL COST	J PAGE TOTAL ACTUAL COST BY FUNDING SOURCE	K TOTAL ACTUAL COST BY FUNDING SOURCE	LINE #
40	Drug Medi - Cal (Federal Share Only) - Fed Cat #93.778						40
40a	Perinatal - Medi-Cal (Federal Share Only) - Fed Cat #93.778				0		40a
40b	Perinatal (PTEP) Match to Medi-Cal				0		40b
41c	Perinatal State General Fund (PSGF)				0		41c
41g	Perinatal Treatment Network Services SGF				0		41g
41h	Perinatal Substance Abuse Treatment SGF				0		41h
41x	Perinatal State General Funds - Backfill				0		41x
45	Female Offender Tx. Proj. - Fed Cat #93.959				0		45
46	Parolee Services Projects (BASN, PPNP, PPP)				0		46
50	SAPT - Discretionary - Fed Cat #93.959				0		50
50a	Adolescent Treatment Services - Fed. Cat #93.959				0		50a
51	HIV Set-Aside - Fed Cat #93.959				0		51
52	SAPT - Perinatal S/A - Fed Cat #93.959				0		52
56	SAPT Special Projects Summary of Funds				0		56
56a	SAPT Discretionary One-Time - Fed Cat #93.959				0		56a
56b	SAPT Drug Courts - Fed Cat #93.959				0		56b
57	SSI/DA/A Funds - Fed Cat #93.959				0		57
57a	SSI/DA/A HIV Funds - Fed Cat #93.959				0		57a
58	DSS/CalWORKs SAPT				0		58
58a	Private Industries Council				0		58a
62	SDFSC-Community Based Prev. - Fed Cat #84.186						62
66	SDFSC-Friday Night Live - Fed Cat #84.186						66
68	SDFSC-Club Live - Fed Cat #84.186						68
68a	CA Mentor Initiative - Fed Cat #84.186						68a
70	State General Fund - Match to Medi-Cal						70
79	TCM/MAA				0		79
80	Non-County Revenue				0		80
80c	State General Fund				0		80c
80e	DSS/CalWORKs State General Funds				0		80e
80x	State General Funds - Backfill						80x
81c	Required County Match (Alcohol/Drug or Perinatal)				0		81c
82	County Funds - Other				0		82
82a	Provider Unrestricted Funds				0		82a
82b	County Unrestricted Funds				0		82b
83	Excess Fees Spent				0		83
84	Fees				0		84
85	Insurance				0		85
86	PC 1463.25 - SB 920 // HS 11372.7 - SB 921				0		86
87	PC 1463.16 - Statham				0		87
87c	Statham Match (Alcohol/Drug or Perinatal)				0		87c
88	Excess DUI Profit/ Suruplus Spent				0		88
89	Driving Under Influence Fees/Admin./Monitoring				0		88
89a	Penal Code 1000 (Admin. Fees)						89
90a	Obligated Unexpended SGF - Prior FY				0		90a
91	TOTAL FUNDING BY SERVICE CATEGORY	0	0	0	0	0	91
93	Excess Fees Carry-over				0		93

94	TOTAL ALCOHOL COSTS - Fed Cat #93.959				0		94
96	TOTAL DRUG COSTS - Fed Cat #93.959				0		96
99	D/MC County Administration				0		99

ADP 7885B (Rev. 7/99)

DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS

COUNTY PREVENTION AND TREATMENT PROGRAMS COST REPORT

SUPPORT SERVICES

FISCAL YEAR 1998-99

This form is to be used as a worksheet in completing the pre-programmed diskette. It is not to be submitted as part of the Cost Report package.

		A	B	C	D	E	F	
*	PROVIDER NAME						PAGE TOTALS	*
*	PROVIDER CODE							*
*	PROGRAM CODE							*
*	SERVICE CODE							
*	Miscellaneous Unit - Mentor Hours (Program Code 12)							*
91	TOTAL ACTUAL COST						0	91
91b	Units of Service - HOURS						0	91b
91c	Cost per Unit of Service	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	91c
	FUNDING SOURCES							
41c	Perinatal State Genral Funds (PSGF)						0	41c
46	Parolee Services Projects (BASN, PPNP, PPP)						0	46
50	SAPT - Discretionary - Fed Cat #93.959						0	50
50a	Adolescent Treatment Services - Fed Cat #93.959						0	50a
52	SAPT - Perinatal S/A - Fed Cat #93.959						0	52
56	SAPT Special Projects Summary of Funds						0	56
56a	SAPT Discretionary One-Time - Fed Cat #93.959						0	56a
56b	SAPT Drug Courts - Fed Cat #93.959						0	56b
58	DSS/CalWORKs SAPT						0	58
58a	Private Industries Council						0	58a
62	SDFSC-Community Based Prev. - Fed Cat #84.186						0	62
66	SDFSC - Friday Night Live - Fed Cat #84.186						0	66
68	SDFSC-Club Live - Fed Cat #84.186						0	68
68a	CA Mentor Initiative - Fed Cat #84.186						0	68a
79	TCM/MAC						0	79
80	Non-County Revenue						0	80
80c	State General Fund						0	80c
80e	DSS/CalWORKs State General Fund						0	80e
81c	Required County Match (Alcohol/Drug or Perinatal)						0	81c
82	County Funds - Other						0	82
86	PC 1463.25 - SB 920 // HS 11372.7 - SB 921						0	86
87	PC 1463.16 - Statham						0	87
87c	Statham Match (Alcohol/Drug or Perinatal)						0	87c
88	Excess DUI Profit / Surplus Spent						0	88
89	Driving Under Influence Admin. & Monitoring						0	89
89a	Penal Code 1000 (Admin. Fees)						0	89a
90a	Obligated Unexpended SGF - Prior FY						0	90a
91	TOTAL FUNDING BY SERVICE CATEGORY	0	0	0	0	0	0	91
93	Excess Fees Carryover					0	0	93

94	TOTAL ALCOHOL COST - Fed Cat #93.959						0	94
96	TOTAL DRUG COST - Fed Cat #93.959						0	96
99	D/MC County Administration							99

ADP 7885C (Rev. 8/99)

DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS
COUNTY PREVENTION AND TREATMENT PROGRAMS COST REPORT
PRIMARY PREVENTION SERVICES
FISCAL YEAR 1998-99

This form is to be used as a worksheet in completing the pre-programmed diskette. It is not to be submitted as part of the Cost Report package.

		A	B	C	D	E	F	
*	PROVIDER NAME						PAGE TOTALS	*
*	PROVIDER CODE							*
*	PROGRAM CODE							*
*	SERVICE CODE							
91	TOTAL ACTUAL COST						0	91
91b	Units of Service - HOURS						0	91b
91c	Cost per Unit of Service	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	91c
	FUNDING SOURCES							
50	SAPT - Discretionary - Fed Cat #93.959						0	50
56	SAPT Special Projects Summary of Funds						0	56
56a	SAPT Discretionary One-Time - Fed Cat #93.959						0	56a
62	SDFSC-Community Based Prev - Fed Cat #84.186						0	62
66	SDFSC-Friday Night Live - Fed Cat #84.186						0	66
68	SDFSC-Club Live - Fed Cat #84.186						0	68
68a	CA Mentor Initative - Fed Cat #84.186							68a
80	Non-County Revenue						0	80
80c	State General Fund						0	80c
81c	Required County Match (Alcohol/Drug or Perinatal)						0	81c
82	County Funds - Other						0	82
83	Excess Fees Spent						0	83
84	Fees						0	84
85	Insurance						0	85
86	PC 1463.25 - SB 920 // HS 11372.7 - SB 921						0	86
87	PC 1463.16 - Statham						0	87
87c	Statham Match (Alcohol/Drug or Perinatal)						0	87c
90a	Obligated Unexpended SGF - Prior FY						0	90a
91	TOTAL FUNDING BY SERVICE CATEGORY	0	0	0	0	0	0	91
93	Excess Fees Carry-over						0	93
94	TOTAL ALCOHOL COST - Fed Cat #93.959						0	94
96	TOTAL DRUG COST - Fed Cat #93.959						0	96
99	D/MC County Administration							99

ADP 7885D (Rev. 7/99)

DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS
COUNTY PREVENTION AND TREATMENT PROGRAMS COST REPORT
SECONDARY PREVENTION SERVICES
FISCAL YEAR 1998-99

This form is to be used as a worksheet in completing the pre-programmed diskette. It is not to be submitted as part of the Cost Report package.

		A	B	C	D	E	F	
*	PROVIDER NAME						PAGE TOTALS	*
*	PROVIDER CODE							*
*	PROGRAM CODE							*
*	SERVICE CODE							*
*	Miscellaneous Unit: MENTOR HOURS (Service Code 24)							*
91	TOTAL ACTUAL COST						0	91
91b	Units of Service - HOURS						0	91b
91c	Cost per Unit of Service	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	91c

FUNDING SOURCES

50	SAPT - Discretionary - Fed Cat #93.959						0	50
50a	Adolescent Treatment Services - Fed Cat #93.959						0	50a
56	SAPT Special Projects Summary of Funds						0	56
56a	SAPT Discretionary One-Time - Fed Cat #93.959						0	56a
56b	SATP Drug Courts - Fed Cat #93.959						0	56b
58	DSS/CalWORKs SAPT						0	58
58a	Private Industries Council						0	58a
62	SDFSC-Community Based Prev - Fed Cat #84.186						0	62
66	SDFSC-Friday Night Live - Fed Cat #84.186						0	66
68	SDFSC-Club Live - Fed Cat #84.186						0	68
68a	CA Menter Initiative - Fed Cat #84.186						0	68a
80	Non-County Revenue						0	80
80c	State General Fund						0	80c
80e	DSS/CalWORKs State General Fund						0	80e
81c	Required County Match (Alcohol/Drug or Perinatal)						0	81c
82	County Funds - Other						0	82
83	Excess Fees Spent						0	83
84	Fees						0	84
85	Insurance						0	85
86	PC 1463.25 - SB 920 // HS 11372.2 - SB 921						0	86
87	PC 1463.16 - Statham						0	87
87c	Statham Metch (Alcohol/Drug or Perinatal)						0	87c
89a	Penal Code 1000 (Admin. Fees)						0	89a
90a	Obligated Unexpended SGF - Prior FY						0	90a
91	TOTAL FUNDING BY SERVICE CATEGORY	0	0	0	0	0	0	91
93	Excess Fees Carry-over						0	93

94	TOTAL ALCOHOL COST - Fed Cat #93.959						0	94
96	TOTAL DRUG COST - Fed Cat #93.959						0	96
99	D/MC County Administration							99

ADP 7885E (Rev. 8/99)

DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS
COUNTY PREVENTION AND TREATMENT PROGRAMS COST REPORT
SECONDARY PREVENTION SERVICES
FISCAL YEAR 1998-99

This form is to be used as a worksheet in completing the pre-programmed diskette. It is not to be submitted as part of the Cost Report package.

		A	B	C	D	E	F	
*	PROVIDER NAME						PAGE TOTALS	*
*	PROVIDER CODE							*
*	PROGRAM CODE							*
*	SERVICE CODE							*
*	Miscellaneous Unit: MENTOR HOURS (Service Code 24)							*
91	TOTAL ACTUAL COST						0	91
91b	Units of Service - HOURS						0	91b
91c	Cost per Unit of Service	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	91c

FUNDING SOURCES

50	SAPT - Discretionary - Fed Cat #93.959						0	50
50a	Adolescent Treatment Services - Fed Cat #93.959						0	50a
56	SAPT Special Projects Summary of Funds						0	56
56a	SAPT Discretionary One-Time - Fed Cat #93.959						0	56a
56b	SATP Drug Courts - Fed Cat #93.959						0	56b
58	DSS/CalWORKs SAPT						0	58
58a	Private Industries Council						0	58a
62	SDFSC-Community Based Prev - Fed Cat #84.186						0	62
66	SDFSC-Friday Night Live - Fed Cat #84.186						0	66
68	SDFSC-Club Live - Fed Cat #84.186						0	68
68a	CA Menter Initiative - Fed Cat #84.186						0	68a
80	Non-County Revenue						0	80
80c	State General Fund						0	80c
80e	DSS/CalWORKs State General Fund						0	80e
81c	Required County Match (Alcohol/Drug or Perinatal)						0	81c
82	County Funds - Other						0	82
83	Excess Fees Spent						0	83
84	Fees						0	84
85	Insurance						0	85
86	PC 1463.25 - SB 920 // HS 11372.2 - SB 921						0	86
87	PC 1463.16 - Statham						0	87
87c	Statham Metch (Alcohol/Drug or Perinatal)						0	87c
89a	Penal Code 1000 (Admin. Fees)						0	89a
90a	Obligated Unexpended SGF - Prior FY						0	90a
91	TOTAL FUNDING BY SERVICE CATEGORY	0	0	0	0	0	0	91
93	Excess Fees Carry-over						0	93

94	TOTAL ALCOHOL COST - Fed Cat #93.959						0	94
96	TOTAL DRUG COST - Fed Cat #93.959						0	96
99	D/MC County Administration							99

ADP 7885E (Rev. 8/99)

DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS
COUNTY PREVENTION AND TREATMENT PROGRAMS COST REPORT
NONRESIDENTIAL SERVICES
Fiscal Year 1998-99

This form is to be used as a worksheet in completing the pre-programmed diskette. It is not to be submitted as part of the Cost Report package.

		A	B	C	D	E	F	
*	PROVIDER NAME						PAGE TOTALS	*
*	PROVIDER CODE							*
*	PROGRAM CODE							*
*	SERVICE CODE							*
*	Miscellaneous Unit - Number of Group Visits (Service Code 33)						0	*
*	Miscellaneous Unit - Number of Group Sessions (Service Code 33)						0	*
*	Miscellaneous Unit - Individual Sessions (Service Code 34)						0	*
91	TOTAL ACTUAL COST						0	91
91b	Unit of Service - Varies						0	91b
91c	Cost Per Unit of Service	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	91c

FUNDING SOURCES

40	Drug Medi - Cal (Federal Share Only) - Fed Cat #93.778						0	40
40a	Perinatal - Medi-Cal (Federal Share Only) - Fed Cat #93.778						0	40a
40b	Perinatal (PTEP) Match to Medi-Cal						0	40b
41c	Perinatal State General Funds (PSGF)						0	41c
41g	Perinatal Treatment Network Services SGF						0	41g
41h	Perinatal Substance Abuse Treatment SGF						0	41h
41x	Perinatal State General Funds - Backfill						0	41x
46	Parolee Services Projects (BASN, PPNP, PPP)						0	46
50	SAPT - Discretionary - Fed Cat #93.959						0	50
50a	Adolescent Treatment Services - Fed #93.959						0	50a
51	HIV Set-Aside - Fed Cat #93.959						0	51
52	SAPT - Perinatal S/A - Fed Cat #93.959						0	52
56	SAPT Special Projects Summary of Funds						0	56
56a	SAPT Discretionary One-Time - Fed Cat #93.959						0	56a
56b	SAPT Drug Courts - Fed Cat #93.959						0	56b
57	SSI/DA/A Funds - Fed Cat #93.959						0	57
58	DSS/CalWORKs SAPT						0	58
58a	Private Industries Council						0	58a
70	State General Fund - Match to Medi-Cal						0	70
79	TCM/MAA						0	79
80	Non-County Revenue						0	80
80c	State General Funds						0	80c
80e	DSS/CalWORKs State General Funds						0	80e
80x	State General Funds - Backfill						0	80x
81c	Required County Match (Alcohol/Drug or Perinatal)						0	81c
82	County Funds - Other						0	82
82a	Provider Unrestricted Funds						0	82a
82b	County Unrestricted Funds						0	82b
83	Excess Fees Spent						0	83
84	Fees						0	84
85	Insurance						0	85
86	PC 1463.25 - SB 920 // HS 11372.7 - SB 921						0	86
87	PC 1463.16 - Statham						0	87
87c	Statham Match (Alcohol/Drug or Perinatal)						0	87c
90a	Obligated Unexpended SGF - Prior FY						0	90a
91	TOTAL FUNDING BY SERVICE CATEGORY	0	0	0	0	0	0	91
93	Excess Fees Carry-over						0	93

94	TOTAL ALCOHOL COST - Fed Cat #93.959						0	94
96	TOTAL DRUG COST - Fed Cat #93.959						0	96
99	D/MC County Administration						0	99

ADP 7885F (Rev. 8/99)

DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS

COUNTY PREVENTION AND TREATMENT PROGRAMS COST REPORT

NARCOTICS TREATMENT

FISCAL YEAR 1998-99

This form is to be used as a worksheet in completing the pre-programmed diskette. It is not to be submitted as part of the Cost Report package.

		A	B	C	D	E	F	
*	PROVIDER NAME						PAGE TOTALS	*
*	PROVIDER CODE							*
*	PROGRAM CODE							*
*	SERVICE CODE							*
*	Miscellaneous Unit - # 10-Minute Group Sessions (Service Code 48)						0	*
*	Miscellaneous Unit - # 10-Minute Indiv. Sessions (Service Code 48)						0	*
*	Miscellaneous Unit - # Methadone Doses Dispensed (Service Code 48)						0	*
*	Miscellaneous Unit - # Meth. Milligrams Dispensed (Service Code 48)						0	*
*	Miscellaneous Unit - # LAAM Doses Dispensed (Service Code 48)						0	*
*	Miscellaneous Unit - # LAAM Milligrams Dispensed (Service Code 48)						0	*
91	TOTAL ACTUAL COST						0	91
91b	Unit of Service - Varies						0	91b
91c	Cost Per Unit of Service	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	91c

FUNDING SOURCES

40	Drug Medi-Cal (Federal Share Only) - Fed Cat #93.778						0	40a
40a	Perinatal - Medi-Cal (Federal Share Only) - Fed Cat #93.778						0	40a
40b	Perinatal (PTEP) Match to Medi=Cal						0	40b
41c	Perinatal State General Fund (PSGF)						0	41c
41g	Perinatal Treatment Network Services (SGF)						0	41g
41h	Perinatal Substance Abuse Treatment (SGF)						0	41h
41x	Perinatal State General Funds - Backfill						0	41x
46	Parolee Services Projects (BASN, PPNP, PPP)						0	46
50	SAPT - Discretionary - Fed Cat #93.959						0	50
50a	Adolescent Treatment Services - Fed Cat #93.959						0	50a
51	HIV Set-Aside - Fed Cat #93.959						0	51
52	SAPT - Perinatal S/A - Fed Cat #93.959						0	52
56a	SAPT Discretionary One-Time - Fed Cat #93.959						0	56a
56b	SAPT Drug Courts - Fed Cat #93.959						0	56b
57	SSI/DA/A Funds - Fed Cat #93.959						0	57
58	DSS/CalWORKs SAPT						0	58
58a	Private Industries Council						0	58a
70	State General Fund - Match to Medi-Cal						0	70
79	TCM/MAA						0	79
80	Non-County Revenue						0	80
80c	State General Funds						0	80c
80e	DSS/CalWORKs State General Funds						0	80e
80x	State General Funds - Backfill						0	80x
81c	Required County Match (Alcohol/Drug or Perinatal)						0	81c
82	County Funds - Other						0	82
82a	Provider Unrestricted Funds						0	82a
82b	County Unrestricted Funds						0	82b
83	Excess Fees Spent						0	83
84	Fees						0	84
85	Insurance						0	85
86	PC 1463.25 - SB 920 // HS 11372.7 - SB 921						0	86
87	PC 1463.16 - Statham						0	87
87c	Statham Match (Alcohol/Drug or Perinatal)						0	87c
90a	Obligated Unexpended SGF - Prior FY						0	90a
91	TOTAL FUNDING BY SERVICE CATEGORY	0	0	0	0	0	0	91
93	Excess Fees Carry-over						0	93

94	TOTAL ALCOHOL COST - Fed Cat #93.959						0	94
96	TOTAL DRUG COST - Fed Cat #93.959						0	96
99	D/MC County Administration						0	99

ADP 7885G (Rev. 8/99)

DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS

COUNTY PREVENTION AND TREATMENT PROGRAMS COST REPORT

NARCOTICS TREATMENT

FISCAL YEAR 1998-99

This form is to be used as a worksheet in completing the pre-programmed diskette. It is not to be submitted as part of the Cost Report package.

		A	B	C	D	E	F	
*	PROVIDER NAME						PAGE TOTALS	*
*	PROVIDER CODE							*
*	PROGRAM CODE							*
*	SERVICE CODE							*
*	Miscellaneous Unit - # 10-Minute Group Sessions (Service Code 48)						0	*
*	Miscellaneous Unit - # 10-Minute Indiv. Sessions (Service Code 48)						0	*
*	Miscellaneous Unit - # Methadone Doses Dispensed (Service Code 48)						0	*
*	Miscellaneous Unit - # Meth. Milligrams Dispensed (Service Code 48)						0	*
*	Miscellaneous Unit - # LAAM Doses Dispensed (Service Code 48)						0	*
*	Miscellaneous Unit - # LAAM Milligrams Dispensed (Service Code 48)						0	*
91	TOTAL ACTUAL COST						0	91
91b	Unit of Service - Varies						0	91b
91c	Cost Per Unit of Service	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	91c

FUNDING SOURCES

40	Drug Medi-Cal (Federal Share Only) - Fed Cat #93.778						0	40a
40a	Perinatal - Medi-Cal (Federal Share Only) - Fed Cat #93.778						0	40a
40b	Perinatal (PTEP) Match to Medi=Cal						0	40b
41c	Perinatal State General Fund (PSGF)						0	41c
41g	Perinatal Treatment Network Services (SGF)						0	41g
41h	Perinatal Substance Abuse Treatment (SGF)						0	41h
41x	Perinatal State General Funds - Backfill						0	41x
46	Parolee Services Projects (BASN, PPNP, PPP)						0	46
50	SAPT - Discretionary - Fed Cat #93.959						0	50
50a	Adolescent Treatment Services - Fed Cat #93.959						0	50a
51	HIV Set-Aside - Fed Cat #93.959						0	51
52	SAPT - Perinatal S/A - Fed Cat #93.959						0	52
56a	SAPT Discretionary One-Time - Fed Cat #93.959						0	56a
56b	SAPT Drug Courts - Fed Cat #93.959						0	56b
57	SSI/DA/A Funds - Fed Cat #93.959						0	57
58	DSS/CalWORKs SAPT						0	58
58a	Private Industries Council						0	58a
70	State General Fund - Match to Medi-Cal						0	70
79	TCM/MAA						0	79
80	Non-County Revenue						0	80
80c	State General Funds						0	80c
80e	DSS/CalWORKs State General Funds						0	80e
80x	State General Funds - Backfill						0	80x
81c	Required County Match (Alcohol/Drug or Perinatal)						0	81c
82	County Funds - Other						0	82
82a	Provider Unrestricted Funds						0	82a
82b	County Unrestricted Funds						0	82b
83	Excess Fees Spent						0	83
84	Fees						0	84
85	Insurance						0	85
86	PC 1463.25 - SB 920 // HS 11372.7 - SB 921						0	86
87	PC 1463.16 - Statham						0	87
87c	Statham Match (Alcohol/Drug or Perinatal)						0	87c
90a	Obligated Unexpended SGF - Prior FY						0	90a
91	TOTAL FUNDING BY SERVICE CATEGORY	0	0	0	0	0	0	91
93	Excess Fees Carry-over						0	93

94	TOTAL ALCOHOL COST - Fed Cat #93.959						0	94
96	TOTAL DRUG COST - Fed Cat #93.959						0	96
99	D/MC County Administration						0	99

ADP 7885G (Rev. 8/99)

DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS
COUNTY PREVENTION AND TREATMENT PROGRAMS COST REPORT
RESIDENTIAL SERVICES
FISCAL YEAR 1998-99

This form is to be used as a worksheet in completing the pre-programmed diskette. It is not to be submitted as part of the Cost Report package.

		A	B	C	D	E	F	
*	PROVIDER NAME						PAGE TOTALS	*
*	PROVIDER CODE							*
*	PROGRAM CODE							*
*	SERVICE CODE							*
91	TOTAL ACTUAL COST						0	91
91b	Unit of Service (NNA = Bed Days; DMC = Per Day)						0	91b
91c	Cost Per Unit of Service	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	91c

FUNDING SOURCES

40a	Perinatal - Medi-Cal (Federal Share Only) - Fed Cat #93.778						0	40a
40b	Perinatal (PTEP) Match to Medi-Cal						0	40b
41c	Perinatal State General Funds (PSGF)						0	41c
41g	Perinatal Treatment Network Services SGF						0	41g
41h	Perinatal Substance Abuse Treatment SGF						0	41h
41x	Perinatal State General Funds - Backfill						0	41x
45	Female Offender Tx. Project - Fed Cat #93.959						0	45
46	Parolee Services Projects (BASN, PPNP, PPP)						0	46
50	SAPT - Discretionary - Fed Cat #93.959						0	50
50a	Adolescent Treatment Services - Fed Cat #93.959						0	50a
51	HIV Set-Aside - Fed Cat #93.959						0	51
52	SAPT - Perinatal S/A - Fed Cat #93.959						0	52
56	SAPT Special Projects Summary of Funds						0	56
56a	SAPT Discretionary One-Time - Fed Cat #93.959						0	56a
56b	SAPT Drug Courts - Fed Cat #93.959						0	56b
57	SSI/DA/A Funds - Fed Cat #93.959						0	57
58	DSS/CalWORKs SAPT						0	58
58a	Private Industries Council						0	58a
79	TCM/MAA						0	79
80	Non-County Revenue						0	80
80c	State General Fund						0	80c
80e	DSS/CalWORKs - State General Fund						0	80e
81c	Required County Match (Alcohol/Drug or Perinatal)						0	81c
82	County Funds - Other						0	82
82a	Provider Unrestricted Funds						0	82a
82b	County Unrestricted Funds						0	82b
83	Excess Fees Spent						0	83
84	Fees						0	84
85	Insurance						0	85
86	PC 1463.25 - SB 920 // HS 11372.7 - SB 921						0	86
87	PC 1463.16 - Statham						0	87
87c	Statham Match (Alcohol/Drug or Perinatal)						0	87c
90a	Obligated Unexpended SGF - Prior FY						0	90a
91	TOTAL FUNDING BY SERVICE CATEGORY	0	0	0	0	0	0	91
93	Excess Fees Carry-over						0	93

94	TOTAL ALCOHOL COST - Fed Cat #93.959						0	94
96	TOTAL DRUG COST - Fed Cat #93.959						0	96
99	D/MC County Administration						0	99

ADP 7885H (Rev. 7/99)

DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS

COUNTY PREVENTION AND TREATMENT PROGRAMS COST REPORT

ANCILLARY SERVICES

FISCAL YEAR 1998-99

This form is to be used as a worksheet in completing the pre-programmed diskette. It is not to be submitted as part of the Cost Report package.

		A	B	C	D	E	F	
*	PROVIDER NAME						PAGE TOTALS	*
*	PROVIDER CODE							*
*	PROGRAM CODE							*
*	SERVICE CODE							*
91	TOTAL ACTUAL COST						0	91
91b	Units of Service - HOURS						0	91b
91c	Cost per Unit of Service	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	91c

FUNDING SOURCES

41c	Perinatal State General Fund (PSGF)						0	41c
41g	Perinatal Treatment Network Services SGF						0	41g
41h	Perinatal Substance Abuse Treatment SGF						0	41h
46	Parolee Services Projects (BASN, PPNP, PPP)						0	46
50	SAPT - Discretionary - Fed Cat #93.959						0	50
50a	Adolescent Treatment Services - Fed Cat #93.959						0	50a
51	HIV Set-Aside - Fed Cat #93.959						0	51
52	SAPT - Perinatal S/A - Fed Cat #93.959						0	52
56a	SAPT Discretionary One-Time - Fed Cat #93.959						0	56a
56b	SAPT Drug Courts - Fed Cat #93.959						0	56b
57a	SSI/DA/A HIV Funds - Fed Cat #93.959						0	57a
58	DSS/CalWORKs SAPT						0	58
58a	Private Industries Council						0	58a
79	TCM/MAA						0	79
80	Non-County Revenue						0	80
80c	State General Fund						0	80c
80e	DSS/CalWORKs State General Fund						0	80e
81c	Required County Match (Alcohol/Drug or Perinatal)						0	81c
82	County Funds - Other						0	82
83	Excess Fees Spent						0	83
84	Fees						0	84
85	Insurance						0	85
86	PC 1463.25 - SB 920 // HS 11372.7 - SB 921						0	86
87	PC 1463.16 - Statham						0	87
87c	Statham Match (Alcohol/Drug or Perinatal)						0	87c
90a	Obligated Unexpended SGF - Prior FY						0	90a
91	TOTAL FUNDING BY SERVICE CATEGORY	0	0	0	0	0	0	91
93	Excess Fees Carry-over						0	93
							0	
94	TOTAL ALCOHOL COST - Fed Cat #93.959						0	94
96	TOTAL DRUG COST - Fed Cat #93.959						0	96
99	D/MC County Administration							99

ADP 7885I (Rev. 7/99)

DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS
COUNTY PREVENTION AND TREATMENT PROGRAMS COST REPORT
DRIVING UNDER THE INFLUENCE PROGRAMS
FISCAL YEAR 1998-99

This form is to be used as a worksheet in completing the pre-programmed diskette. It is not to be submitted as part of the Cost Report package.

		A	B	C	D	E	F	
*	PROVIDER NAME						PAGE TOTALS	*
*	PROVIDER CODE							*
*	PROGRAM CODE							*
*	SERVICE CODE							*
91	TOTAL ACTUAL COST						0	91
91b	Units of Service - Persons Served						0	91b
91c	Cost per Unit of Service	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	91c

FUNDING SOURCES

80	Non-County Revenue						0	80
80c	State General Fund *NOTE						0	80c
82	County Funds - Other						0	82
85	Insurance						0	85
87	PC 1463.16 - Statham						0	87
88	Excess DUI Profit/ Surplus Spent						0	88
89	Driving Under the Influence Participant Fees						0	89
90a	Obligated Unexpended SGF - Prior FY						0	90a
91	TOTAL FUNDING BY SERVICE CATEGORY	0	0	0	0	0	0	91
97	DUI Profit/Surplus						0	97
98	Excess DUI Profit/Surplus Carryover						0	98

NOTE: SGF MAY ONLY BE USED IN COUNTIES WITH POPULATIONS THAT DO NOT EXCEED 20,000.

ADP 7885K (Rev. 7/99)

COUNTY PREVENTION AND TREATMENT PROGRAM COST REPORT
INSTRUCTIONS FOR PREPARATION
COST REPORT WORKSHEETS
FY 1998-99

ADP 7885 A through K

NOTE: The "FY 1998-99 DMC Cost Report Forms" diskette contains the file which includes the formulas for these forms. The EXCEL file names are: 89-7885, 89-7885A, 89-7885B, 89-7885C, 89-7885D, 89-7885E, 89-7885F, 89-7885G, 89-7885H, 89-7885I, and 89-7885K. Do not enter information in the cells where a "0" or "#DIV/0!" is located. These areas will automatically be calculated.

Use these worksheets as a tool for completion of the pre-programmed diskette. They are not to be submitted to ADP as part of the Cost Report package.

ADP 7885A & B – COLUMN INSTRUCTIONS – Page 1 of 2

COLUMN A Enter the grand totals from the corresponding lines from the Support Services cost report form (ADP 7885C, Column F, Line 41c through Line 96).

COLUMN B Enter the grand totals from the corresponding lines from the Primary Prevention Services cost report form (ADP 7885D, Column F, Line 50 through Line 96).

COLUMN C Enter the grand totals from the corresponding lines from the Secondary Prevention Services cost report form (ADP 7885E, Column F, Line 50 through Line 96).

COLUMN D Enter the grand totals from the corresponding lines from the Nonresidential Services cost report form (ADP 7885F, Column F, Line 40 through Line 99).

COLUMN E Enter the grand totals from the corresponding lines from the Narcotics Treatment Services cost report form (ADP 7885G, Column F, Line 40 through Line 99).

COLUMN F Total the amounts in Columns A through E.

ADP 7885A & B – COLUMN INSTRUCTIONS – Page 2 of 2

COLUMN G Enter the grand totals from the corresponding lines from the Residential Services cost report form (ADP 7885H, Column F, Line 40a through Line 99).

COLUMN H Enter the grand totals from the corresponding lines from the Ancillary Services cost report form (ADP 7885I, Column F, Line 41c through Line 96).

COLUMN I Enter the grand totals from the corresponding lines from the Driving Under the Influence Program cost report form (ADP 7885K, Column F, Line 80 through Line 90a).

COLUMN J Total the amounts in Columns G, H, and I.

COLUMN K Enter the total of Column F from page 1 and Column J from Page 2 for Lines 40 through 99.

ADP 7885C through ADP 7885I – INSTRUCTIONS

GENERAL Use a separate column for each provider, for each facility, and service provided.

LINE INSTRUCTIONS:

- Enter the provider name.
- Enter the 6-digit provider code (assigned by ADP).
- Enter the 1 or 2 digit program code.
- Enter the 2-digit service code of the service provided
- Enter the applicable miscellaneous Unit. They are:
  - Service Codes 00, 01, 02, 03, 04, 05, 06, and 24: Mentor Hours
  - Service Code 33: # of Group Visits and Group Sessions
  - Service Code 34: # of Individual Sessions
  - Service Code 48: Group Session, Individual Sessions, Methadone Doses, Methadone Milligrams, LAAM Doses, and LAAM Milligrams

- Line 91: Enter the provider's total actual cost.
- Line 91b: Enter the total number of units of service as it pertains to program code and service type for each provider, each facility, and each service.
- Line 91c: Enter the cost per unit of service, divide Line 91 by Line 91b.
- Line 40 through 89a: Enter the actual costs funded for the specific funding for each line that is applicable.
- Line 90a: Enter any unexpended State General Funds from prior fiscal years – expend in this cost report year.
- Line 93: Enter the total amount of excess fees accrued in cost report year to be carried over to the next fiscal year.
- Line 94: Enter the amount of Federal Catalog number 93.959 funds, for each provider, for alcohol services.
- Line 96: Enter the amount of Federal Catalog number 93.959 funds, for each provider, for drug services.

  NOTE FOR LINES 94 AND 96: The amounts must equal the sum of the amounts in Lines 45, 50, 50a, 51, 52 and 56.

COLUMN INSTRUCTIONS:

- Column F: Enter the totals from Columns A through E. Column F must be calculated for each page.

CROSS CHECK:

- For each column, both Line 91's must be the same.

ADP 7885K – INSTRUCTIONS

GENERAL Use a separate column for each provider, for each facility, and service provided.

LINE INSTRUCTIONS:

- Enter the provider name.
- Enter the 6-digit provider code (assigned by ADP).
- Enter the 1 or 2 digit program code.
- Enter the 2-digit service code of the service provided
- Line 91: Enter the provider's total actual cost. Do not include cost for County Administration and Monitoring.
- Line 91b: Enter the total number of persons served for each provider, each facility, and each service.
- Line 91c: Enter the cost per unit of service, divide Line 91 by Line 91b.
- Line 80 through 89: Enter the actual costs funded for the specific funding for each line that is applicable. Do not include fees collected and submitted to the county for Administration and Monitoring.
- Line 91: Enter the total of amounts reported on Lines 80 through 89.
- Line 97: Enter profit collected through participant fees not to exceed 10% of the total collected.
- Line 98: Enter the total amount of excess DUI profit accrued in cost report year and carried over to the next fiscal year. Excess DUI profit is defined as profit that exceeds 10% of revenue from total participant fees.

COLUMN INSTRUCTIONS:

- Column F: Enter the totals from Columns A through E. Column F must be calculated for each page.

CROSS CHECK:

- For each column, both Line 91's must be the same.

FUNDING DESCRIPTIONS
Fiscal Year 1998-99

Alcohol/Drug Medi-Cal (Federal Share Only) Fed. Cat. #93.778 (Funding Line #40)

This funding is the Federal Financial Participation (FFP) share of 51.23 percent for July 1, 1998, through September 30, 1998, and the FFP share of 51.55 percent for October 1, 1998, through June 30, 1999, for alcohol and drug services for Drug Medi-Cal (DMC) eligible beneficiaries.

Perinatal - Medi-Cal (Federal Share Only) Fed. Cat. #93.778 (Funding Line #40a)

This funding is the FFP share of 51.23 percent for July 1, 1998, through September 30, 1998, and the FFP share of 51.55 percent for October 1, 1998, through June 30, 1999, for perinatal services for DMC eligible beneficiaries.

Perinatal (PTEP) - Match to Medi-Cal (Funding Lines #40b)

This funding is the Perinatal Treatment Expansion (PTEP) SGF share of 48.77 percent for July 1, 1998, through September 30, 1998, and the PTEP SGF share of 48.45 percent for October 1, 1998, through June 30, 1999, for perinatal services for DMC eligible beneficiaries.

Perinatal State General Fund (Funding Line #41c)

This funding is allocated to provide sufficient Perinatal State General Fund (P/SGF) to meet the DMC need in counties identified in the Departments' projections.

Perinatal Treatment Network Services (PTNS) – SGF (Funding Line #41g)

These funds were awarded to four (4) perinatal treatment programs that were previously funded by the Federal grant, Center for Substance Abuse Treatment (CSAT).

These funds must be shown as separate and independent expenditures, within a specific provider, from other perinatal programs.

Perinatal Substance Abuse Treatment (PSAT) – SGF (Funding Line #41h)

These funds were awarded to successful applicants of the PSAT's Request for Application which was issued to the counties October 13, 1998. These funds were awarded to provide a wide-range of services which include outreach, day care habilitative, outpatient drug free, aftercare, narcotic replacement therapy, detoxification, residential recovery, transitional living center, alcohol and drug free housing, interim services, and case management.

These funds must be shown as separate and independent expenditures, within a specific provider, from other perinatal programs.

Perinatal State General Fund – Backfill (Funding Line 41x)

These are State General Fund dollars that can be used to backfill DMC overages for DMC perinatal programs.

Female Offender Treatment Project (Fed. Cat. #93.959) (Funding Line #45)

These funds are used to provide aftercare treatment (residential only) for paroled female inmates primarily from the California Institution for Women. The affected counties are Los Angeles, Orange, Riverside, and San Bernardino. Specific funding requirements have been provided directly to the affected counties. No Female Treatment Offender Project funds may be used for County administrative costs.

Parolee Services Networks (BASN, PPNP, PPP) (Funding Line #46)

These funds are made available by the California Department of Corrections (CDC) for residential and non-residential alcohol and drug treatment and/or recovery services to inmates and parolees in the counties of Alameda, Contra Costa, Fresno, Los Angeles, Marin, Napa, San Diego, San Francisco, San Mateo, Santa Clara, Solano, and Sonoma.

Specific funding requirements have been provided directly to the affected counties.

Substance Abuse Prevention and Treatment (SAPT) Block Grant (Fed. Cat. #93.959)

These funds are awarded for the purpose of planning, carrying out, and evaluating activities to prevent and treat substance abuse and authorized related activities. States are required to expend no less than 35 percent for prevention and treatment activities regarding alcohol and no less than 35 percent for prevention and treatment activities regarding other drugs. Twenty percent of the States' SAPT Block Grant funds must be spent on Primary Prevention activities.

For specific funding and program requirements, please refer to the Federal SAPT Block Grant Law (July 1992) and the Federal SAPT Block Grant Regulations (March 1993).

a. Discretionary (Fed. Cat. #93.959) (Funding Line #50)

Block grant funds are used for a wide range of activities to prevent and treat substance abuse and dealing with the abuse of alcohol, the use or abuse of illicit drugs, the abuse of licit drugs, and the use or abuse of tobacco products.

These discretionary block grant funds awarded are for the purposes other than those block grant funds specifically identified, i.e., HIV Set-Aside, Perinatal Set-Aside, etc.

b. Adolescent Treatment Services (ATS) (Fed. Cat. #93.959) (Funding Line #50a)

These funds allocated are for services other than Primary Prevention and Driving Under the Influence programs.

c. HIV Set Aside (Fed. Cat. #93.959) (Funding Line #51)

These funds are allocated to counties to make available to individuals (undergoing treatment for substance abuse) early intervention services for HIV diseases. Services are voluntary and will not be required as a condition of receiving treatment services. These services include appropriate pre-test counseling, testing individuals, appropriate post-test counseling, and providing therapeutic measures in relationship to the testing.

HIV Set-Aside funds may only be used in treatment programs.

d. SAPT - Perinatal Set Aside (Fed. Cat. #93.959) (Funding Line #52)

These funds are awarded to increase the availability of treatment services for pregnant women and women with dependent children.

These funds may be used by counties to expand static capacity in existing perinatal programs, add new perinatal programs/services (e.g., case management), and change existing programs. These funds cannot be used to supplant funds that support existing perinatal services.

e. Special Projects - Summary of Funds (Funding Line #56)

Special Projects - Funds are allocated for special projects to the following counties: Alameda, Los Angeles, Modoc, and Tulare.

Specific terms and conditions were provided directly to the affected counties.

f. SAPT Discretionary One-Time (Funding Line #56a)

Block grant funds are used for a wide range of activities to prevent and treat substance abuse and dealing with the abuse of alcohol, the use or abuse of illicit drugs, the abuse of licit drugs, and the use or abuse of tobacco products.

These one-time discretionary block grant funds are awarded for purposes other than those block grant funds specifically identified, i.e., HIV Set-Aside, Perinatal Set-Aside, etc.

g. SAPT Drug Courts (Funding Line #56b)

These funds were awarded to counties on a competitive basis through the Drug Court-Related Substance Abuse Treatment Request for Applications (RFA) to develop and expand drug court-related substance abuse treatment. The project year began March 1, 1999.

SSI-DA/A Funds - Fed. Cat. #93.959 (Funding Line #57)

As the result of federal funding for displaced Supplemental Security Income Drug Addiction and Alcoholism (SSI- DA/A) clients, the Department allocated Supplemental Security Income Drug Addiction or Alcoholism funds to counties based on the California Alcohol and Drug Data System (CADDS) data to those counties with SSI-DA/A clients. The 20 percent primary prevention set-aside and the 35/35 alcohol/drug requirement do not apply. However, the HIV Services set-aside and all other requirements of the SAPT Block Grant do apply.

SSI-DA/A HIV Funds - Fed. Cat. #93.959 (Funding Line #57a)

Five percent of the total SSI- DA/A allocation is designated for SSI- DA/A HIV.

DSS/CalWORKs SAPT (Funding Line #58)

These funds are to provide substance abuse services to CalWORKs recipients for the purpose of removing barriers to employment. CalWORKs clients must have substance abuse treatment identified as part of their Welfare to Work Plan. The SAPT set-aside requirements have already been satisfied, but all other SAPT requirements still apply for utilizing these funds. **These funds were allocated by Department of Social Services.**

Private Industries Council (PIC) (Funding Line #58a)

ADP must track funds from the Employment Development Department (EDD) being used for substance abuse services through the NNA contract process for Welfare-to-Work funding.

Safe and Drug-Free Schools and Communities (SDFSC) Funds Fed. Cat. # 84.186

Priority for expenditure of the federal Safe and Drug-Free School and Communities (SDFSC) funds shall be given to programs and activities for:

* Children and youth who are not normally served by State or local educational agencies; or
* Populations that need special services or additional resources (such as preschoolers, youth in juvenile detention facilities, runaway or homeless children and youth, pregnant and parenting teenagers, and school dropouts.

Use of funds is limited to:

- No more than 5 percent of the allocated funds may be used for administrative costs.

- Funding under this category may be used to support parent groups, community action agencies, community-based organizations, and other public entities and private nonprofit entities for the development and implementation of programs such as:

a. **Community Based Prevention (Funding Line #62)**

These funds are limited to services for Ahigh-risk youth≅ as defined in federal statute. The 10 percent school, school district, or community organization hard match is not a requirement.

b. **Friday Night Live Program (Funding Line #66) and Club Live Program (Funding Line #68)**

The Friday Night Live (FNL) Program is a peer program tailored for each county to meet local needs, receiving minimal financial support from state and federal funds.

Club Live (CL) is a program for junior or middle school youth with components similar to the FNL Program but designed for the difficult transition years between elementary and high school.

The development of new FNL and CL Programs is targeted toward high-risk schools and their surrounding communities. ADP funds contracted for FNL and CL may be used only for items directly related to the operation of the FNL/CL Program. A county may also elect to redirect additional Federal SDFSC funds to its FNL/CL Program.

California Mentor Initiative (CMI)- Fed. Cat. #84.186 (Funding Line #68a)

SDFSC Act funds are being used to support the expansion of local mentor service programs across the state. For the purposes of the CMI, mentoring is defined as a relationship over a prolonged period of time between two or more people where older, wiser, more experienced individuals provide constant, as needed support, guidance, and concrete help to the younger at-risk persons as they go through life. An "at-risk " youth is an individual under 19 years of age whose environment increases his/her chance of becoming a teen parent, school drop-out, gang member, or user of alcohol or drugs. Targeted children and youth must not be normally served by State or local educational agencies or must be in need of special services or additional resources. Funding under the CMI is restricted to five percent administrative costs.

Service Code 24 is the CMI service code and may only be used for Secondary Prevention (code 24 only), and Support Services (codes 00-06 only). The unit of service is staff hours while the ancillary unit is mentor hours.

State General Fund (SGF) - Match to Medi-Cal (Funding Line #70)

This funding is the State General Fund (SGF) share of 48.77 percent for July 1, 1998, through September 30, 1998, and the SGF share of 48.45 percent for October 1, 1998, through June 30, 1999, for alcohol and drug services for DMC eligible beneficiaries.

TCM – MAA (Funding Line #79)

TCM - MAA funds are Medicaid. Because DHS is identified by the Federal Government as the single state agency, they are responsible for managing the claiming and cost reporting process.

Targeted Case Management (TCM) services are defined in Welfare and Institutions Code Section 14132.44. TCM services are to be provided to specific groups of Medi-Cal beneficiaries, one of which is alcohol and drug abusers. Providers are local governments under contract with DHS. Providers must submit an annual cost report to DHS. Local government providers may subcontract with service providers.

Medi-Cal Administrative Activity (MAA) is defined in Welfare and Institutions Codes Section 14132.47. The intent of MAA is to assist with the performance of administrative activities necessary for the proper and efficient administration of the Medi-Cal program. Like TCM, DHS contracts with local government providers, who may subcontract with non-governmental entities for provision of services.

Non-County Revenue (Funding Line #80)

This funding line is for revenue from sources other than allocated or county-generated. Examples of non-county revenue are non-Federal grants, donations, contributions, and third party payments other than insurance.

State General Fund (SGF) (Funding Line #80c)

These SGF dollars can be used for discretionary purposes only after adequate funding has been provided for DMC alcohol and drug services and DMC perinatal services, if applicable.

If DMC is not applicable, the counties have the discretion to expend the funds for alcohol and drug services and perinatal services as long as appropriate funding requirements are met.

For counties with a population of over 100,000, SGF not used as federal DMC match has a 10 percent match requirement.

DSS/CalWORKs SGF (Funding Line #80e)

These funds are to be used for mental health services or substance abuse services. These funds are not matchable to any federal funds. County Welfare Directors have the option of moving these funds between their CalWORKs substance abuse services and their CalWORKs mental health services based on a county=s specific need for each type of service. These funds were allocated by Department of Social Services.

Regular State General Fund – Backfill (Funding Line #80x)

These State General Fund dollars can be used for DMC overages in the DMC Alcohol/Drug Program or Perinatal Program.

Required County Match - Alcohol/Drug or Perinatal (Funding Lines #81c)

Counties shall comply with the following county match requirements pursuant to Health and Safety Code, Sections 11840, 11840a.1, and 11987.4:

a. Counties with population over 100,000:

   1. State General Fund (SGF) allocations, if any, not used as D/MC match shall be funded on the basis of 90 percent SGF and 10 percent county funds, except local hospital inpatient costs, to the extent there are allocations made for local hospital inpatient costs;

   2. State Hospital programs shall be funded on the basis of 85 percent SGF and 15 percent county funds.

b. Counties with population less than 100,000:

   1. State Hospital programs shall be funded on the basis of 90 percent SGF and 10 percent county funds to the extent that allocations of SGF are made available for alcohol and drug treatment in State Hospital programs.

c. Perinatal Services Network counties with population over 100,000:

   Perinatal SGF, if any not used as DMC match, shall be funded on the basis of 90 percent Perinatal SGF and 10 percent county funds. The 10 percent county match funds must be used in perinatal programs.

County Funds - Other (Funding Line #82)

These are funds provided by the county in excess of the above-cited match requirements, i.e., general assistance and probation funds, administered by the County Alcohol and Drug administrator.

Provider Unrestricted Funds (Funding Line #82a)

This is a DMC line only. Costs for rates that exceed the rate cap will be accepted; however, the Department will not reimburse in excess of the rate cap. Costs in excess of the rate cap must be accounted for in the unrestricted funds lines.

County Unrestricted Funds (Funding Line #82b)

This is a D/MC line only. Costs for rates that exceed the rate cap will be accepted; however, the Department will not reimburse in excess of the rate cap. Costs in excess of the rate cap must be accounted for in the unrestricted funds lines.

Excess Fees Spent (Funding Line #83)

These are fees that were collected from clients in the previous fiscal year, but not expended in the same year collected.

These funds cannot be spent in Support Services (HSC Sections 11841 and 11991.5).

Fees (Funding Line #84)

This amount is the projected amount of fees collected from clients for the fiscal year.

Each provider using state or federal funds must assess and collect fees from participants and report fees on its budget forms, except Prevention.

These funds cannot be spent in Support Services (HSC Sections 11841 and 11991.5).

Insurance (Funding Line #85)

This amount is the projected fees collected from third party payers.

These funds cannot be spent in Support Services (HSC Sections 11841 and 11991.5).

PCS 1463.25 (SB 920) and HS 11372.7 (SB 921) (Funding Line #86)

SB 920 (Alcohol Abuse Education and Prevention Penalty Assessment) and SB 921 (Controlled Substance Abuse Penalty Fee) require fines to be collected by the county for violations and convictions of alcohol/drug related offenses. These funds shall be identified and accounted for separately. A minimum of 33 percent of the funds shall be allocated to primary prevention programs in the schools and the community. These funds shall supplement and not supplant any local funds made available to support the county=s alcohol and drug abuse education and prevention efforts.

PC 1463.16 - Statham (Funding Line #87) and Statham Match - Alcohol/Drug or Perinatal (Funding Line #87c)

Statham funds are fines imposed for violations of Vehicle Code sections 23103, 23104, 23152, or 23153. Statham funds shall be used to encourage the development of privately operated programs before developing publicly operated programs at the local level, and development shall include upgrading of facilities to promote ADP certification and licensing standards and to increase accessibility for handicapped persons.

Statham funds are not to be used for drug programs or as county match for drug programs. To the extent the funds are used for combined drug/alcohol programs, the funds should be used for the alcohol component of the program and only when that program is certified or has applied for certification.

The match funds may also be used to match Alcohol/Drug combined programs for alcohol clients only as well as Perinatal programs for alcohol clients only.

Excess Driving Under the Influence (DUI) Profit/Surplus Spent (Funding Line #88)

Profit/surplus in excess of 10 percent of costs must be included in the DUI program in the next fiscal year.

DUI Fees & Admin. & Monitoring (Funding Line #89)

There is a 5 percent cap of gross participant fees for the administration and monitoring of the driving under the influence programs. If over the 5 percent cap, a waiver from the DUI Program Branch of ADP is required for each fiscal year.

Penal Code (PC) 1000 (Admin. Fees) (Funding Line #89a)

This funding line represents the amount of fees for the administration and monitoring of the Drug Diversion programs.

Obligated Unexpended State General Funds (SGF) - Prior Fiscal Year (Funding Line #90a)

This is for all counties that may have unexpended FY 1997-98 SGF dollars that are to be expended in FY 1998-99.

Total Alcohol Cost - Fed. Cat. #93.959 (Funding Line #94)

This is the total amount of SAPT Block Grant funds that were expended for prevention and treatment activities regarding alcohol. No less than 35 percent is required to be spent.

Total Drug Cost - Fed. Cat. #93.959 (Funding Line #96)

This is the total amount of SAPT Block grant funds that were expended for prevention and treatment activities regarding other drugs. No less than 35 percent is required to be spent.

DUI Profit/Surplus - (Funding Line #97)

This is the DUI Profit/Surplus funds which are within the 10 percent allowable profit or surplus.

Excess DUI Profit/Surplus To Be Carried- Over - (Funding Line #98)

This is the amount above and beyond the 10 percent DUI Profit/Surplus collected that must be budgeted and expended in the next fiscal year.

D/MC County Administration - (Funding Line #99)

This funding line captures the county expenses related to administration of the D/MC program.

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SERVICE CODE LISTING AND DESCRIPTIONS

Fiscal Year 1998-99

Service Code	Service Code Name	Applicable Program Codes
SUPPORT SERVICES		
00	County Support	1 – 12, 14, 15, 20
01	Quality Assurance	1 – 12, 14, 15, 20
02	Training	1 - 12, 14 - 20
03	Program Development	1 - 12, 13, 14, 15, 20
04	Research and Evaluation	1 – 12, 20
05	Planning, Coordination, Needs Assessment	1 – 12, 20
06	Start Up Costs	1, 3, 4, 5, 6, 7, 10, 11, 12, 14, 15, 20
08	Cost Efficiencies	N/A for cost reports
09	Facility Construction or Rehabilitation	1, 3, 4, 5, 6, 7, 10, 11
PRIMARY PREVENTION		
11	Other - Primary Prevention	1, 4, 5, 6, 7, 13
12	Information Dissemination	1, 4, 5, 6, 7, 13
13	Education	1, 4, 5, 6, 7, 13
14	Alternatives	1, 4, 5, 6, 7, 13
15	Problem Identification and Referral	1, 4, 5, 6, 7, 13
16	Community-Based Process	1, 4, 5, 6, 7, 13
17	Environmental	1, 4, 5, 6, 7, 13
SECONDARY PREVENTION		
18	Early Intervention	1, 4, 5, 6, 7, 20
19	Outreach and Intervention	1, 4, 5, 6, 7, 16, 18, 20
20	Intravenous Drug User (IDU or IVDU)	1, 4, 5, 6, 7, 16, 18, 20
21	Referral, Screening, and Intake	1, 4, 5, 6, 7, 14, 15, 16, 18, 20
24	California Mentor Initiative (CMI)	12

NONRESIDENTIAL		
30	Rehabilitation Ambulatory Intensive Outpatient (Day Care Habilitative)	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 14, 15, 16, 17, 18, 19, 20, 90, 91, 93, 94, 95, 96
32	Aftercare	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 14, 15, 16, 17, 18, 19, 20
33	Rehabilitative/Ambulatory Outpatient or Outpatient Drug Free (ODF) – Group	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 14, 15, 16, 17, 18, 19, 20, 90-99
34	Rehabilitative/Ambulatory Outpatient or Outpatient Drug Free (ODF) - Individual	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 14, 15, 16, 17, 18, 19, 20, 90 - 99
35	Interim Treatment Services - CalWORKs	14, 15
41	Outpatient Methadone Detoxification (OMD)	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 14 – 20
42	Inpatient Methadone Detoxification (IMD)	1, 2, 4, 5, 6, 7, 8, 9, 14 – 20
43	Naltrexone Treatment	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 14, 15, 16, 17, 18, 19, 20, 90, 94, 97 - 99
44	Rehabilitative Ambulatory Detoxification (Other than Methadone)	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 14 – 20
48	Narcotic Replacement Therapy (NTP) - All Services	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 14-20, 90, 91, 93 - 99
RESIDENTIAL		
50	Free-Standing Residential Detoxification	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 14, 15, 16, 17, 18, 19, 20
51	Residential Recovery - Long Term (over 30 days)	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 14 - 20, 91, 93, 95, 96
52	Residential Recovery - Short Term (up to 30 days)	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 14 - 20, 91, 93, 95, 96
53	Hospital Inpatient Detoxification (24 hours)	1, 3, 4, 5, 6, 7, 10, 11, 14 – 20
54	Hospital Inpatient Residential (24 hours)	1, 3, 4, 5, 6, 7, 10, 11, 14 – 20
55	Chemical Dependency Recovery Hospital (CDRH)	1, 3, 4, 5, 6, 7, 14 – 20
56	Transitional Living Center (Perinatal and Parolee Only)	2, 3, 8, 9, 10, 11
57	Alcohol- and Drug-Free Housing (Parolee Only)	2, 3, 8, 9, 10, 11

ANCILLARY SERVICES		
22	Perinatal Outreach/Publicity	3, 10, 11, 17, 19
63	Cooperative Projects	1, 3, 4, 5, 6, 7, 10, 11
64	Vocational Rehabilitation	1, 4, 5, 6, 7, 14 – 20
65	HIV Early Intervention Services	1, 3, 4, 5, 6, 7, 16, 17, 18, 19
66	Tuberculosis Services	1, 3, 4, 5, 6, 7, 10, 11, 16, 17, 18, 19, 20
67	Interim Services (within 48 hours)	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 14 – 20
68	Case Management	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 14 – 20
69	Primary Medical Care (Perinatal Only)	3, 10, 11, 17, 19
70	Pediatric Medical Care (Perinatal Only)	3, 10, 11, 17, 19
71	Transportation (Parolee Only)	2, 8, 9, 14 – 19
DRIVING UNDER THE INFLUENCE		
90	Driving Under the Influence	1, 4, 5, 6, 7

SERVICE CODE DESCRIPTIONS
Fiscal Year 1998-99

These service code definitions are identified in the FY 1993-94 Appendices of Guidelines for Preparation and Submission of Substance Abuse Prevention and Treatment Plan for County Alcohol and Drug Programs. Other references are indicated in brackets.

SUPPORT SERVICES

00 - County Support

This includes administrative, management, and support functions not specifically defined in the other Support Services components. [Federal Definition]

01 - Quality Assurance

This includes activities to assure conformity to acceptable professional standards and identify problems that need to be remedied. These activities may occur at the State, county, or program level. County administrative agency contracts to monitor service providers fall in this category, as do peer review activities. [Federal Definition]

02 - Training

Post-Employment - This includes staff development and continuing education for personnel employed in local programs as well as support and coordination agencies, as long as the training relates to substance abuse service delivery. Typical costs include course fees, tuition and expense reimbursements to employees, trainer and support staff salaries, and certification expenditures. [Federal Definition]

03 - Program Development

This includes consultation, technical assistance, and materials support to local providers and planning groups. Normally these activities are carried out by State and county level agencies. [Federal Definition]

04 - Research and Evaluation

This includes activities or components related to research and evaluation of clinical trials, demonstration projects to test feasibility and effectiveness of a new approach, and performance evaluation of service programs. These activities might be carried out by the State agencies or a county contractor. [Federal Definition]

05 - Planning, Coordination, Needs Assessment

This includes State, regional, and local personnel salaries pro-rated for time spent in planning meetings, data collection, analysis, writing, and travel. It also includes operating costs such as printing, advertising, and conducting meetings. Any contracts with community agencies or local governments for planning and coordination fall in this category, as do needs assessment projects to identify the scope and magnitude of the problem, resources available, gaps in services, and strategies to close those gaps. [Federal Definition]

06 - Start Up Costs

Those costs associated with the initial development of a program within the 90 days immediately prior to the provider's ability to provide services. Typically, these costs include (but are not limited to) those for administrative and staff salaries, training, rent, utilities, and repairs. [Federal Definition]

08 - Cost Efficiencies

Cost efficiencies are designated State General Funds (SGF) and/or Perinatal SGF savings available on April 1 as carryover for use in the next fiscal year. County match funds must be included. [ADP Letter #97-17 dated March 24, 1997]

This service code is for budget purposes only and is not used in the cost report.

09 - Facility Construction or Rehabilitation

This includes costs associated with the construction or rehabilitation of alcohol recovery/ drug treatment facilities. A waiver must be granted by the Federal government prior to using SAPT funds. [Federal Definition]

PRIMARY PREVENTION

11 - Other

The six primary prevention strategies, codes 12 through 17, have been designed to encompass nearly all of the prevention activities. However, in the unusual case an activity does not fit one of the six strategies, it may be classified in the "Other" category. [Federal Definition and ADP Letter #96-47 dated September 19, 1996]

12 - Information Dissemination

This strategy provides awareness and knowledge of the nature and extent of alcohol, tobacco and drug use, abuse and addiction and their effects on individuals, families and communities. It also provides knowledge and awareness of available prevention programs and services. Information dissemination is characterized by one-way communication from the source to the audience, with limited contact between the two. Examples of activities conducted and methods used for this strategy include (but are not limited to) the following:

a. Clearinghouse/information resource center(s);
b. Resource directories;
c. Media campaigns;
d. Brochures;
e. Radio/TV public service announcements;
f. Speaking engagements;
g. Health fairs/health promotion; and
h. Information lines.

[Federal Definition]

13 - Education

This strategy involves two-way communication and is distinguished from the Information Dissemination strategy by the fact that interaction between the educator/facilitator and the participants is the basis of its activities. Activities under this strategy aim to affect critical life and social skills, including decision-making, refusal skills, critical analysis (e.g., of media messages) and systematic judgment abilities. Examples of activities conducted and methods used for this strategy include (but are not limited to) the following:

a. Classroom and/or small group sessions (all ages);
b. Parenting and family management classes;
c. Peer leader/helper programs;
d. Education programs for youth groups; and
e. Children of substance abusers groups.

[Federal Definition]

14 - Alternatives

This strategy provides for the participation of target populations in activities that exclude alcohol, tobacco and other drug use. The assumption is that constructive and healthy activities offset the attraction to, or otherwise meet the needs usually filled by, alcohol, tobacco and other drugs and would, therefore, minimize or obviate resorting to the latter. Examples of activities conducted and methods used for this strategy include (but are not limited to) the following:

a. Drug free dances and parties;
b. Youth/adult leadership activities;
c. Community drop-in centers; and
d. Community service activities.

[Federal Definition]

15 - Problem Identification and Referral

This strategy aims at identification of those who have indulged in illegal/age-inappropriate use of tobacco or alcohol and those individuals who have indulged in the first use of illicit drugs in order to assess if their behavior can be reversed through education. It should be noted, however, that this strategy does not include any activity designed to determine if a person is in need of treatment. Examples of activities conducted and methods used for this strategy include (but are not limited to) the following:

a. Employee assistance programs;
b. Student assistance programs; and
c. Driving while under the influence/driving while intoxicated education programs.

[Federal Definition]

16 - Community-Based Process

This strategy aims to enhance the ability of the community to more effectively provide prevention and treatment services for alcohol, tobacco and drug abuse disorders. Activities in this strategy include organizing, planning, enhancing efficiency and effectiveness of services implementation, inter-agency collaboration, coalition building and networking. Examples of activities conducted and methods used for this strategy include (but are not limited to) the following:

a. Community and volunteer training, e.g., neighborhood action training, training of key people in the system, staff officials training;

b. Systematic planning;
c. Multi-agency coordination and collaboration;
d. Accessing services and funding; and
e. Community team-building. [Federal Definition]

17 - Environmental

This strategy establishes or changes written and unwritten community standards, codes and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco, and other drugs used in the general population. This strategy can be divided into two subcategories to permit distinction between activities which center on legal and regulatory initiatives and those which relate to the service and action-oriented initiatives. Examples of activities conducted and methods used for this strategy shall include, but not be limited to, the following:

a. Promoting the establishment and review of alcohol, tobacco and drug use policies in schools;
b. Technical assistance to communities to maximize local enforcement procedures governing availability and distribution of alcohol, tobacco and other drug use;
c. Modifying alcohol and tobacco advertising practices; and
d. Product pricing strategies.

[Federal Definition]

SECONDARY PREVENTION - These strategies do not count toward the 20 percent primary prevention requirement

18 - Early Intervention

This strategy is designed to come between a substance user and his or her actions in order to modify behavior. It includes a wide spectrum of activities ranging from user education to formal intervention and referral to appropriate treatment/recovery services.

19 - Outreach and Intervention

This service code is defined as activities for the purpose of encouraging those individuals in need of treatment to undergo such treatment.

20 - Intravenous Drug User (IDU or IVDU)

Activities for the purpose of encouraging those individuals in need of treatment to undergo such treatment.

21 - Referrals, Screening, and Intake

Activities involved in the assessment of a client's needs regarding treatment to ensure the most appropriate treatment. This may include the completion of record-keeping documents.

24 - California Mentor Initiative (CMI)

The CMI is designed to enhance and expand mentor service programs across the state. For the purposes of CMI, mentoring is defined as a relationship over a prolonged period of time between two or more people where older, wise, more experienced individuals provide constant, as needed support, guidance, and concrete help to the younger at-risk persons as they go through life. An "at-risk" youth is an individual under 19 years of age whose environment increases his/her chance of becoming a teen parent, school dropout, gang member, or user of alcohol or drugs.

Targeted children and youth must not be normally served by the State or local educational agencies or must be in need of special services or additional resources. [Title IX, Section 4114(b) of the Safe and Drug Free Schools and Communities (SDFSC) Act]

Funding under the CMI is restricted to five percent administrative costs and secondary prevention services. [Title IX, Section 4114(a)(3) of the SDFSC Act]

This code is to be used for Secondary Prevention (code 24 only) and Support Services (codes 00-06 only). Units of service are staff hours. Mentor hours are displayed in the field titled ADescription≅.

NONRESIDENTIAL

30 - Rehabilitative Ambulatory Intensive Outpatient (Day Care Habilitative)

Day Care Habilitative (DCH) services are those that last two or more hours but less than 24 hours per day for three or more days per week. Programs that are DMC certified are required to provide services that last three or more hours but less than 24 hours, per day, for three or more days per week. This service definition includes day care habilitative programs which provide counseling and rehabilitation services to Medi-Cal beneficiaries with substance abuse impairments. Clients may live independently, semi-independently, or in a supervised residential facility which does not provide this service. DCH differs from

Outpatient Drug Free care in which clients participate according to a minimum attendance schedule and have regularly assigned treatment activities.

Medi-Cal Beneficiaries: DMC reimbursement for Day Care Habilitative services shall be available only for services provided to pregnant and postpartum beneficiaries or beneficiaries under the age of 21 who are targeted for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services. Only pregnant and postpartum women are eligible to receive DMC drug abuse services through perinatal certified programs. The postpartum period is defined as a sixty (60) day period beginning on the last day of pregnancy, regardless of whether other conditions of eligibility are met. Eligibility shall end on the last day of the calendar month in which the 60th day occurs. Parenting women who are Medi-Cal eligible are still eligible for regular D/MC services (non-Perinatal State General funds) and non-DMC perinatal programs. [Title 22, July 1, 1998]

32 - Aftercare

Structured services offered to an individual who has completed treatment, typically for a set period of time (e.g., six months), to ensure successful recovery.

33 - Rehabilitative/ Ambulatory Outpatient or Outpatient Drug Free (ODF) -Group

Treatment/recovery or rehabilitation services provided where the client does not reside in a treatment facility. The client receives drug abuse or alcoholism treatment services with or without medication, including counseling and/or supportive services. This is also known as nonresidential services in the alcoholism field. [Federal Definition]

For Program Codes 1 – 11, providers that receive **only NNA funding** are required to identify staff hours; however they have the option of reporting the total number of group sessions and the number of individuals in those group sessions.

For all Applicable Program Codes, providers that receive both NNA and DMC funding are required to report the total number of staff hours, the total number of group sessions and the number of individuals in those group sessions.

Medi-Cal Beneficiaries Only: Each client shall receive two group counseling sessions (minimum 90 minutes per group session) per 30-day period depending on his/her needs and treatment plan or be subject to discharge. Group counseling means face-to-face contacts in which one or more counselors treat four or more clients, up to a total of ten clients, at the same time, focusing on the needs of the individuals served. [Title 22, July 1, 1998]

34 - Rehabilitative/Ambulatory Outpatient or Outpatient Drug Free (ODF) - Individual

Treatment/recovery or rehabilitation services provided where the client does not reside in a treatment facility. The client receives drug abuse or alcoholism treatment services with or without medication, including counseling and/or supportive services. This is also known as nonresidential services in the alcoholism field. [Federal Definition]

For Program Codes 1 – 11, providers that receive **only NNA funding** are required to identify staff hours; however, they have the option of reporting the total number of individual sessions.

For All Applicable Program Codes, providers that receive both NNA and DMC funding are required to report staff hours as well as the total number of individual sessions.

Medi-Cal Beneficiaries Only: Each shall receive individual counseling, which is face-to-face contact between a client and a therapist or counselor. Individual counseling is limited to intake, evaluation, assessment and diagnosis, treatment and discharge planning, collateral services, and crisis intervention. [Title 22, July 1, 1998]

35 - Interim Treatment Services - CalWORKs

This service code will be utilized for CalWORKs clients whose use of alcohol or drugs has interfered with their performance in the workplace or in school. Each client will receive short-term outpatient treatment services (no longer than eight weeks) of group and/or individual counseling sessions depending on his or her needs. This service includes any activity designed to assist the individual in determining a need for more intensive alcohol and other drug treatment.

NARCOTICS TREATMENT SERVICES

40 - Narcotic Replacement Therapy (NRT) - Methadone (Not A Reportable Number - See Number 48)

This service element is comprised of the provision of methadone as prescribed by a physician to alleviate the symptoms of withdrawal from narcotics; and other required/ appropriate activities and services provided in compliance with California Code of Regulations (CCR) Title 9, Chapter 4, beginning with Section 10000. Services include intake, assessment and diagnosis; all medical supervision; urine drug screening; individual and group counseling; admission physical examinations and laboratory tests.

41 - Outpatient Methadone Detoxification (OMD)

This service element is comprised of the provision of narcotic withdrawal treatment pursuant to CCR Title 9, beginning with Section 10000, to clients who, with the aid of medication, are undergoing a period of planned withdrawal from narcotic drug dependence. Withdrawal without medication is not considered detoxification treatment for reporting purposes.

42 - Inpatient Methadone Detoxification (IMD)

In a controlled, 24-hour hospital setting, this service element is comprised of the provision of narcotic withdrawal treatment pursuant to CCR Title 9, beginning with Section 10000, to clients who, with the aid of medication are undergoing a period of planned withdrawal from narcotic drug dependence. Withdrawal without medication is not considered detoxification for reporting purposes.

43 - Naltrexone Treatment

The use of Naltrexone (Trexan) is to block the effects of heroin and other narcotics or opioids, such as codeine, pentazocine (Talwin), morphine, oxycodone (Percodan), and hydromorphone (Dilaudid). Services include medication; medical direction; medically necessary urine screens for use of substances; counseling; and other appropriate activities and services.

44 - Rehabilitative Ambulatory Detoxification (Other than Methadone)

Rehabilitative ambulatory detoxification is defined as outpatient treatment services rendered in less than 24 hours that provide for safe withdrawal in an ambulatory setting (pharmacological or nonpharmacological). [Federal Definition]

45 - Narcotic Replacement Therapy (NRP) - LAAM (Not A Reportable Number - See Number 48)

LAAM is an opioid medication that is used as one component of a comprehensive replacement narcotic therapy program, which includes medical evaluation, treatment planning, and counseling. [Title 22, July 1, 1998]

46 - NRT Group Counseling (Not A Reportable Number - See Number 48)

Face-to-face contacts in which one or more therapists or counselors treat two ore more clients at the same time, focusing on the needs of the individuals served. For DMC reimbursement, groups must have a minimum of four and a maximum of 10 persons; at least one must be a Medi-Cal eligible beneficiary. [Title 22, July 1, 1998]

47 - NRT Individual Counseling (Not A Reportable Number - See Number 48)

Face-to-face contacts between a beneficiary and a therapist or counselor. Telephone contacts, home visits, and hospital visits shall not qualify as Medi-Cal reimbursable units of service. [Title 22, July 1, 1998]

48 - NRT All Services

This Service Code combines all Service Codes 40, 45, 46, and 47 so all components and NNA and DMC costs can be entered within one area.

For All Applicable Service Codes, providers are required to report slot days to determine cost per unit and are also required to report the number of methadone doses, the number of methadone milligrams dispensed, the number of LAAM doses, the number of LAAM milligrams dispensed, the number of 10-minute group counseling sessions, and the number of 10-minute individual counseling sessions.

RESIDENTIAL

NOTE: The Department must license all non-medical adult residential facilities that provide alcohol and drug treatment services on-site. Providers should contact ADP=s Quality Assurance Division for licensure information.

50 - Free-Standing Residential Detoxification

Free-standing residential detoxification is defined as services in a non-hospital setting that provide for safe withdrawal and transition to ongoing treatment. [Federal Definition]

51 - Residential/Recovery Long Term (over 30 days)

Long-term residential care is typically over 30 days of nonacute care in a setting with recovery/treatment services for alcohol and other drug use and dependency [Federal Definition]. Services are provided by program-designated personnel and include the following elements: personal recovery/treatment planning; educational sessions; social/ recreational activities; individual and group sessions; detoxification services; and information about, and may include assistance in obtaining, health, social, vocational, and other community services.

Perinatal residential funding is intended for gender specific residential services tailored to meet the recovery and treatment needs of women and their children. [Title 22, July 1, 1998]

Medi-Cal Beneficiaries Only: Only pregnant and postpartum women are eligible to receive DMC drug abuse services through perinatal certified programs. The postpartum period is defined as a sixty (60) day period beginning on the last day of pregnancy, regardless of whether other conditions of eligibility are met. Eligibility shall end on the last day of the calendar month in which the 60th day occurs. Parenting women who are Medi-Cal eligible are still eligible for non-DMC services (non-Perinatal State General Funds and non-DMC perinatal programs). [Title 22, July 1, 1998]

The licensed treatment capacity of a facility eligible for DMC perinatal certification cannot be more than 16 persons. Beds occupied by children are not counted toward the 16-bed limit. The facility may not share food, shelter, treatment or services with another alcohol or drug recovery or treatment residential facility unless the combined treatment capacity of all the facilities is 16 or less. [Title 22, July 1, 1998]

52 - Residential/Recovery Short Term (up to 30 days)

Short-term residential care is typically 30 days or less of nonacute care in a setting with recovery/treatment services for alcohol and other drug abuse and dependency [Federal Definition].

Services are provided by program-designated personnel and include the following elements: personal recovery/treatment planning; educational sessions; social/recreational activities; individual and group sessions; and information about, and may include assistance in obtaining, health, social, vocational, and other community services.

Perinatal residential funding is intended for gender specific residential services tailored to meet the recovery and treatment needs of women and their children.

Medi-Cal Beneficiaries: Only pregnant and postpartum women are eligible to receive DMC-funded drug abuse services through Perinatal certified programs. The postpartum period is defined as a sixty (60) day period beginning on the last day of pregnancy, regardless of whether other conditions of eligibility are met. Eligibility shall end on the last day of the calendar month in which the 60th day occurs. Parenting women who are Medi-Cal eligible are still eligible for regular DMC services (non-Perinatal State General funds) and non-DMC perinatal programs. [Title 22, July 1, 1998]

Licensed treatment capacity of a facility eligible for DMC perinatal certification cannot be more than 16 persons. Beds occupied by children are not counted toward the 16-bed limit. The facility may not share food, shelter, treatment or services with another alcohol or drug recovery or treatment residential facility unless the combined treatment capacity of all the facilities is 16 or less. [Title 22, July 1, 1998]

53 - Hospital Inpatient Detoxification (24 Hours)

Hospital inpatient detoxification is defined as medical acute care services for detoxification for persons with severe medical complications associated with withdrawal. (SAPT Block Grant Funds cannot be used to fund these services). [Federal Definition]

54 - Hospital Inpatient Residential (24 Hours)

Hospital inpatient residential care is medical care (other than detoxification) in a hospital facility in conjunction with treatment services for alcohol and other drug abuse and dependency. (SAPT Block Grant Funds cannot be used to fund these services). [Federal Definition]

55 - Chemical Dependency Recovery Hospital (CDRH)

All treatment programs, or components thereof, located in a Department of Health Services= licensed CDRH fall under this service definition. Services are provided on the basis of a 24-hour day unit of service. State General Funding used for this service must have a county match of 90%. This requirement is identified in DDP Letter #83-65 dated December 29, 1983. [Title 22, Chapter 11]

56 - Transitional Living Center (Perinatal and Parolee Services)

A Transitional Living Center (TLC) is a facility designed to help persons maintain an alcohol-and-drug free lifestyle and "transition" back into the community. TLC activities are supervised, although not necessarily 24 hours per day, within an alcohol- and drug-free environment. Attendance at recovery and treatment services is mandatory, although those services need not be on-site. If services are provided on-site, ADP must license the facility. TLCs are not required to provide child care, case management, transportation, education, or primary or pediatric care as the provision of these services are the responsibility of the treatment program the resident attends. [Perinatal Services Guidelines - Fall 1995]

57 - Alcohol/Drug-Free Housing (ADFH) - (Parolee Only)

ADFH centers help recovering persons to maintain an alcohol- and drug-free lifestyle. Residents are free to organize and participate in self-help meetings or any other activity that helps them maintain sobriety. The house or its residents do not and cannot provide any treatment, recovery, or detoxification services; do not have treatment or recovery plans or maintain resident files; and do not have a structured, scheduled program of alcohol and drug education, group or individual counseling, or recovery support sessions.

Only ADFH centers participating in the Parolee Services Network are eligible for ongoing funding. Only the start-up phase of ADFHs can be funded with SGF. Start-up costs are limited to the following one-time expenditures that prepare the residence for occupancy: first and last month=s deposit to secure a property; security and utilities deposits; and furniture that meets basic needs. Federal funds **cannot** be used to start or fund ADFHs on an ongoing basis. [Perinatal Services Guidelines - Fall 1993]

ANCILLARY SERVICES

22 - Perinatal Outreach

Perinatal Outreach is an element of service that identifies and encourages eligible pregnant and parenting women in need of treatment services to take advantage of these services. Outreach may also be used to educate the professional community on perinatal services so that they become referral sources for potential clients. [Perinatal Services Network Guidelines - Fall 1995]

63 - Cooperative Projects

This code allows for funding of special projects that have been approved by the Department prior to funding. [ADP Letter #96-21 dated April 12, 1996] Cooperative Projects are those which the Department and a County conjointly utilize strategies and activities to expand or enhance alcohol and drug services.

64 - Vocational Rehabilitation

Services which provide for gaining and maintaining job skills which will allow for productive employment. Vocational rehabilitation includes vocational testing, counseling, guidance, job training, job placement, and other relevant activities designed to improve the alcoholic person's ability to become economically self-supporting. [Alcohol Services Reporting System Manual]

65 - HIV Early Intervention Services

Those activities involved in the prevention and delay of the progression of HIV by encouraging HIV counseling, testing, assessment of the progression of the disease and the provision of prophylactic and anti-viral prescription drugs.

66 - Tuberculosis (TB) Services

These services provide counseling and testing regarding tuberculosis offered to individuals either seeking treatment or receiving treatment for substance abuse.

67 - Interim Services (within 48 hours)

Interim services are those services offered to injecting drug users or pregnant women seeking substance abuse treatment who cannot be admitted to a program due to capacity limitations.

68 - Case Management

Case Management services are activities involved in the integrating and coordinating of all necessary services to ensure successful treatment and recovery. Services may include outreach, intake, assessment, individual services plans, monitoring and evaluation of progress, and community resource referrals.

NOTE: Programs that receive perinatal funds must provide or arrange for case management services. [Perinatal Services Guidelines - Fall 1993]

69 - Primary Medical Care (Perinatal Only)

This is an element required in SAPT Block Grant funded perinatal programs. The program must provide or arrange for this service, which does not include specialist care or hospitalization for pregnant women and women with dependent children who are receiving substance abuse services. If the care is not covered by a third party provider, SAPT Block Grant funds may be used as the payment of last resort. This service must include referrals for prenatal care. [Perinatal Guidelines - Fall 1993]

70 - Pediatric Medical Care (Perinatal Only)

This is an element required in SAPT Block Grant funded perinatal programs. The program must provide or arrange for this service, which does not include specialist care or hospitalization for the children of women who are receiving substance abuse services. If the care is not covered by a third party provider, SAPT Block Grant funds may be used as the payment of last resort. This service must include immunizations.

71 - Transportation (Parolee Services Only)

This service is the provision of or arrangement for the transportation of a client to and from treatment services.

DRIVING UNDER THE INFLUENCE

90 - Driving Under the Influence

This service is a first offender, 18-month, or 30-month alcohol and drug education and counseling program for persons who have a driving or boating violation involving alcohol and/or other drugs, which has been recommended by the county board of supervisors and is licensed by the Department.

STATE OF CALIFORNIA

DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS

NNA and DMC COST REPORT

FY 1998-99 FISCAL DATA ENTRY DISKETTE

USER INSTRUCTIONS

August 1999

INSTALLATION OF PARADOX NNA-DMC COST REPORT DISKETTE

NOTE: If you have uninstalled PARADOX Runtime Version 4.5, you must reinstall it before installing this diskette. If you no longer have the installation diskettes for PARADOX Runtime, contact your assigned Fiscal Management Branch analyst.

You will need at least 7 MB of free disk space to install the diskette.

1. Insert the NNA-DMC Cost Report diskette into the appropriate drive.

2. Go to Program Manager for Windows 3.1 and select AFile≅ or select the AStart≅ button for Windows 95 and select ARun≅:

   a. Type a:\install or b:\install on the Command Line (dependent upon the drive into which the diskette was inserted) and click on "OK";
   b. Click on "OK" for each of the two directories to be installed on your C drive.

3. The Install program will then execute and, upon completion, the icon "98-99 NNA-DMC Cost Report" will be displayed on your screen.

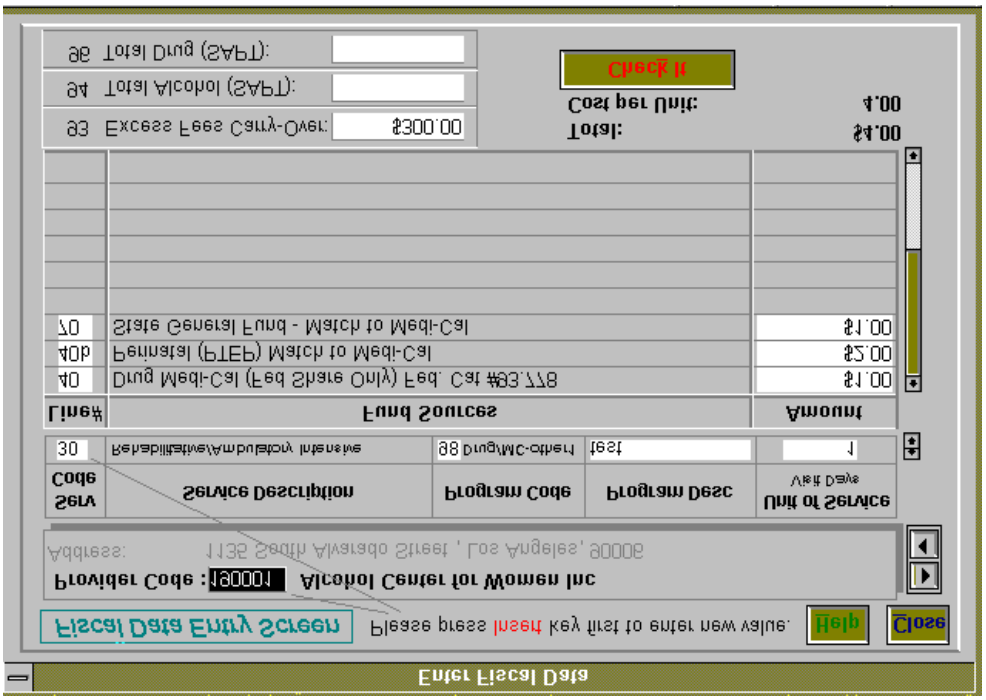
   For Windows 95 or Windows NT, the Paradox Runtime Version 4.5 does not support automatic set report orientation. **You have to manually set the paper orientation for your printer**. The following reports are to printed on Portrait: Fiscal Detail by Modality, County Allocation Report, and Error Message Report. **The Prevention/Treatment Summary Report is to be printed on Landscape.**

   To select the paper orientation, select AMy Computer≅, select APrinters Folder≅, select the Printer - in Properties, set the appropriate Paper Orientation) before printing the report.

   A laser printer is preferred for printing as the reports will run faster and produce better results.

4. Remove the diskette from the drive, and **PLEASE KEEP THIS DISKETTE IN A SAFE PLACE.**

FISCAL DATA ENTRY SCREEN INFORMATION



Click on right arrow button to move to next provider in the table. Click on left arrow button to move to previous provider.

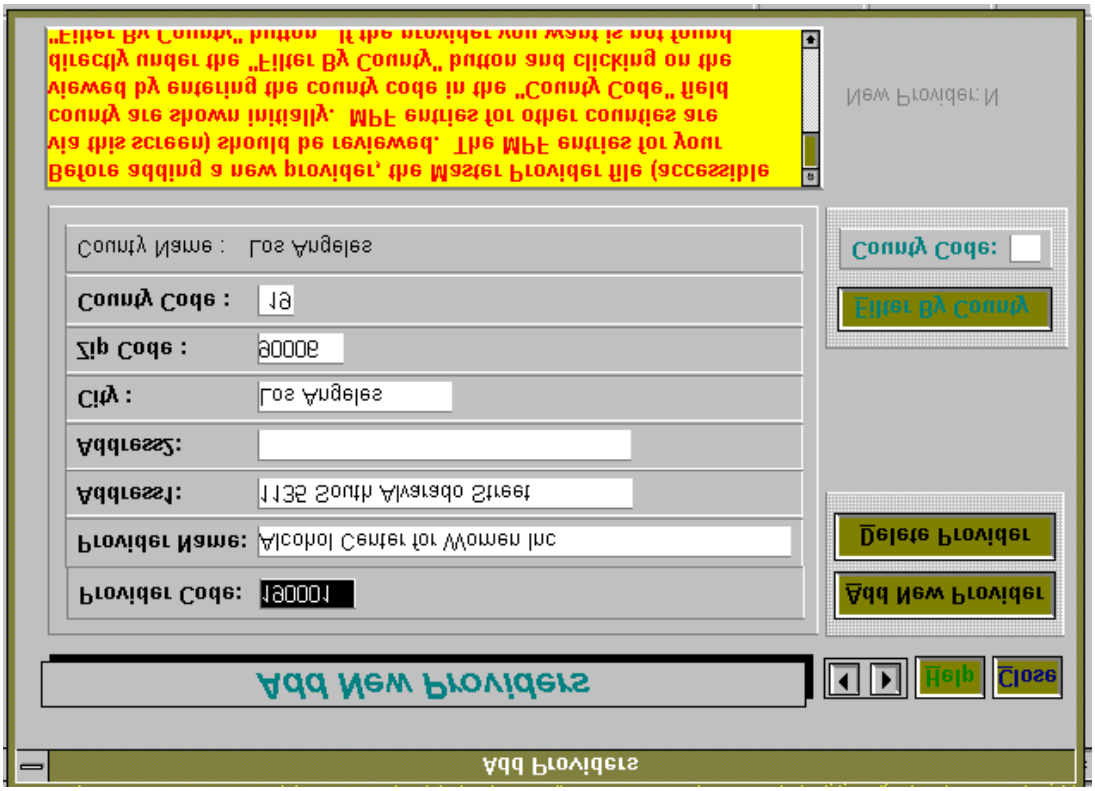
Click on up arrow to move to next service code in the table. Click on down arrow to move to previous service code.

Click on up arrow to move up in Fiscal Amount entries. Click on down arrow to move down in Fiscal Amount entries.

When you finish all fiscal entries for one service code and program, click “Check It” to complete provider level edits.

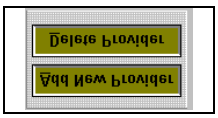
To enter a provider, move to the provider code field and press INSERT key.
To enter a service code, move to the service code field and press INSERT key.
To change a Unit of Service or Fiscal Amount fields, use backspace key
To delete Fiscal Amount lines, move to the line # field, then press CTRL + DELETE keys.
To delete service or program codes, delete Fiscal Amount lines first, move to the service or program field, press CTRL + DELETE keys.
If you cannot move out of a field, press CTRL + DELETE.
Lookup help is available for provider code, service code, program code, and line # fields move to the field and press CTRL + space bar simultaneously.

ENTER NEW PROVIDER SCREEN INFORMATION



When this screen presents, it shows the first provider in the Master Provider File (MPF) for the county. By entering the county code in the "County Code" field directly under the "Filter By County" button and clicking on the "Filter by County" button, providers in the MPF in other counties may be displayed. Review the MPF to ensure that you do not attempt to add a provider that already exists within the MPF.

Use the left and right arrow keys to scroll through the listing of existing providers within the chosen county. The providers are listed by the county in which the facility is physically located.



These buttons are only necessary to 1) add a provider that is not found in the MPF; or 2) to delete a provider that is not found in the MPF (e.g., you add a provider in error).

Enter the county code in the "County Code" field and click on the "Filter By County" button to view MPF entries for other counties.

Use the up and down arrows to scroll through the instructions for the use of this screen.

USE OF NNA and DMC COST REPORT DATA ENTRY PROGRAM

I. Getting Started:

When the Cost Report program is selected, the main selection screen displays the county name and five choices in the Menu bar section: "Data Entry", "Reports", "Backup", "Help", and "Exit". Your county=s diskette contained the most recent version of your FY 1998-99 NNA-DMC Budget data as it appears on the Department=s data base. However, there are a few areas, such as for Service Code 48 (NRT All Services) that will require complete entry of the fiscal expenditure data.

II. Data Entry:

This screen selection is divided into two areas:

- Enter Fiscal Data
- Enter New Provider

NOTE: Enter the Driving Under the Influence (DUI) Administration and Monitoring fees retained by the county separately using the Support Services service element rather than the DUI service element.

A. General Information and Instructions:

1. Look-up Tables

Use these tables when in a data entry screen. These screens appear throughout the program to assist you in the Fiscal Data Entry, Provider Code lookup, and Add Provider screens. To access the lookup tables, click on that field to highlight and press CTRL and the space bar simultaneously.

The lookup tables are in following areas:

Provider Code (Fiscal Data Entry Screen):

This diskette contains the MPF, a subset of the California Alcohol and Drug Data System. When accessed, this lookup table displays all providers and provider numbers for each selected county. To find a provider located in another county, simply change the county code and click on the "Filter by County Code" button. You cannot change provider data such as the name or address. Should you find the information on a provider to be incorrect, please contact your assigned Fiscal Management Branch analyst.

Service Code (Fiscal Data Entry Screen):

All service codes are maintained with the title of that code. Select the proper code and the title will list out automatically.

Cost Report Program Code (Fiscal Data Entry Screen):

Entries for fiscal data are divided into seven program areas: Alcohol and Drug, Perinatal, Parolee, Mentor, Drug Courts, and Drug Medi-Cal (DMC). This is to ensure the separate accounting of funds and units of service for these seven areas. The counties have historically separated fiscal entries within the same provider number, service code, and program code. Except for the sub-programs of DMC Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) and Minor Consent, this separate of fiscal entries is allowed for all four program areas on this diskette by use of the program code selection of AOther≅. If AOther≅ is chosen, you must also enter a description of the program.

All entries of AOther≅, with the exception of the Fiscal Detail reports, will be added together in all reports based on the program description to which the code number corresponds. These entries will be maintained as separate records within the database.

The Cost Report Program Codes for FY 1998-99 are as follows:

1 = NNA Alcohol/Drug
2 = NNA Parolee
3 = NNA Perinatal
4 = NNA Alcohol/Drug - Other
5 = NNA Alcohol/Drug - Other
6 = NNA Alcohol/Drug - Other
7 = NNA Alcohol/Drug - Other
8 = NNA Parolee - Other
9 = NNA Parolee - Other
10 = NNA Perinatal - Other
11 = NNA Perinatal - Other
12 = NNA Mentor (In Need of Treatment)
13 = NNA Mentor (Not In Need of Treatment)
14 = NNA/DSS CalWORKs
15 = NNA/DSS CalWORKs - Other
16 = NNA/Drug Court - Alcohol/Drug
17 = NNA/Drug Court - Perinatal
18 = NNA/Drug Court Partnership – Alcohol/Drug
19 = NNA/Drug Court Partnership – Perinatal
20 = NNA Adolescent Treatment
90 = D/MC EPSDT
91 = D/MC EPSDT (Perinatal)
92 = D/MC Minor Consent
93 = D/MC Minor Consent (Perinatal)
94 = D/MC Private Pay
95 = D/MC Perinatal
96 = D/MC Perinatal - Other
97 = D/MC Alcohol/Drug
98 = D/MC Alcohol/Drug - Other
99 = D/MC Alcohol/Drug – Other

Line Number (Fiscal Data Entry Screen):

To ensure the entry of valid fund sources for service codes and program codes, a table of line numbers (fund sources) was created for each service code within each program type. Only those line numbers valid for your selection of service code and program code will appear in this lookup table.

County Code (Provider Code lookup screen and Add New Provider screens):

All counties and their county number appear in this table.

2. **Function Keys:**

Three function keys are also used:

F3 moves the cursor backward from Amount to Unit of Service to Provider Code;

F4 moves the cursor forward from Provider Code to Service Code to Line Number; and,

F9 enter and exit from Edit mode.

B. **Enter Fiscal Data**

NOTE: The FY 1998-99 NNA and DMC provider and budget information is downloaded on the diskette. **However, there are a few areas, such as for Service Code 48 (NRT All Services) that will require complete entry of the fiscal expenditure data.**

Upon selecting "Enter Fiscal Data" from the main menu, the provider code field will contain the first provider and service code within the table for that county. To view entries of other providers, click on the left or right arrow buttons positioned to the right of the Provider Code field. To view other service or program codes for the same provider, click on the up and down arrow buttons to the right of the Service Code line. If you cannot move out of a field, try pressing CTRL + DELETE at the same time to delete the

record. **Enter funding without dollar signs or commas.** The program will enter them upon pressing the "ENTER" or cursor keys.

Always press the INSERT key first to add a new provider or service code. After entering data for a provider, service code, and Line Number, you can check for certain provider level edits by clicking on the "Check It" button. If there are no errors, "PASS" will be displayed at the bottom left side of the screen. Any error messages are displayed in a box in the middle of the screen.

When you have completed all fiscal entries, click on the "Close" button in the upper right corner of the screen. This will return you to the main screen.

1. Additional Service or Program Code - Same Provider

   If additional data for the same provider but a different service code is to be entered, highlight the service code field and then press the "INSERT" key. A blank screen will display a message at the bottom stating that the record is locked for changes. You may then enter the new service code and remaining information. If you do not know the service code or program code, use the Lookup table(s) by highlighting the necessary field and pressing CTRL and the space bar at the same time.

2. Additional Provider Data

   If additional data for a different provider is to be entered, highlight the provider code field and then press the "INSERT" key. A blank screen will display a message at the bottom stating that the record is locked for changes. You may then enter the provider code and the remaining information. If you do not know the provider code, use the lookup table (CTRL + space bar) to locate the provider (in any county) for which you wish to enter data.

3. Deletion/Correction

Once the service code and units are entered for a provider, you cannot go back and change the service code or program code without deleting the record first, starting with all funding. Once funds have been entered for a specific Line Number, you may not change the Line Number without deleting the funding first.

a. To delete a Line Number record, move to the Line Number field and hold down the CTRL key and then press the DELETE key simultaneously.

b. To delete a Service Unit record, delete all Line Number records first then move to either Service Code or Program Code and hold down the CTRL key and then press the DELETE key simultaneously.

c. To delete a Provider record, delete all Line Numbers and Service Codes first, then move to the Provider Code field and press CTRL and DELETE keys at the same time.

d. To simply correct an error in a field, use the BACKSPACE or DELETE key. You may change the dollar amounts and the service units via this method. Please do not zero out the dollar amount. Instead, delete the record for the Line Number.

e. To move funds from one provider to another, delete the entire record for the incorrect provider and reenter the information for the correct provider.

For the combined NNA and DMC Cost Report, the DMC units of service must be entered as follows:

1. Outpatient Drug Free (ODF) - Group:

   For Program Codes 1 through 11, providers that receive both NNA and DMC funding **are required to report staff hours as well as the total number of group sessions and the number of individuals in those group sessions (number of group visits).**

2. Outpatient Drug Free (ODF) - Individual:

   For Program Codes1 through 11, providers that receive both NNA and DMC funds **are required to report staff hours as well as the total number of individual sessions.**

3. For Day Care Habilitative (DCH), providers **are required to report visits days.**

4. Residential (RES):

   a. For Program Codes 1 through 11, providers **are required to report (available) bed days.**

   b. For Program Codes 91, 93, 95, and 96, providers **are required to report number of days.**

5. Narcotic Treatment Program (NTP)

   a. For Program Codes 1 through 20, providers **are required to report slot days.**

   b. For Program Codes 90 through 99, providers **are required to report slot days, as well as total methadone doses, total methadone milligrams dispensed, total LAAM doses, total LAAM milligrams dispensed, total 10-minute group counseling sessions, and total 10-minute individual counseling sessions.**

6. Naltrexone (NAL):

   a. For Program Codes 1 through 11, and 14 through 20, providers **are required to report slot days.**

   b. For Program Codes 90, 94, 97, 98, and 99, providers **are required to report visits.**

C. **Add New Provider**

To add a new provider that is not in the MPF, use the "Enter New Provider" selection. If the provider you are adding is located in another county, use the provider number for the location where services are provided. Providers are listed by number in the county where the facility is physically located and not within all counties with which the provider may have a contract.

To locate a provider in another county, highlight (by clicking) the county code field in the Provider Look-up screen in the lower right under the "Filter by County" button, enter the appropriate county code, and click on the "Filter by County" button. You can then scroll through the providers in that county with the left and right pointing arrows until you locate the provider. If you do not know the county code, CTRL + space bar will provide the county code lookup table. Locate the county in the listing, and press the ENTER key or click on "OK" to place the county code in the field. Then click on the "Filter by County" button to receive the listing of providers for that county.

If you enter an existing provider number as a new provider, all information from the MPF will be presented on the screen. You may not change information on an existing provider. If the information within the MPF is incorrect, please contact the Department to correct the file. Do not enter a new provider record to correct information for that provider.

Information regarding new providers may be edited. Please use a temporary number starting with the letter "T" followed by your 2 digit county code and a 3 digit provider number. Follow Departmental protocol for establishing new providers.

IV. Reports:

This selection allows you to print the Fiscal Detail pages by modality, the Summary Fiscal Report, a printout of the county's allocation, and the Error Message Report.

A. Fiscal Detail Report by Modality

The Fiscal Detail selection provides a screen listing of the modalities to be printed. The screen default is for all reports to be printed. If a modality report is not requested, click on that field to remove the check mark. You may also request to view the report on the screen. To page through multiple entries, use the page selection in the menu bar. If a request for printing is not made, the program will return to the main selection screen. To exit, click on the "minus" sign in the upper left corner of the screen.

B. Prevention/Treatment Summary Report

Select the Prevention/Treatment Summary Report to print the various summary reports. **Reminder: These must be printed landscape**.

C. County Allocation Report

The County Allocation Report is a listing of the allocated amounts for that county by fund source and line number. In those cases where more than one fund source is combined for a line number, the total of the sources, and not the individual amounts, appears.

D. Error Message Report

After all fiscal information has been entered, run this report. The Error Message Report lists the edits which pertain to the fiscal entries. These edits check various rules such as the budgeted amount not exceeding the allocation, the 20 percent Prevention Set-Aside, etc.

In response to edits performed at the summary level, the following messages appear:

1. "No more than 10 percent of the total Parolee Services Project funds may be used in Support Services."
2. "No more than 5 percent of the total SDFSC - School Based Prevention funds may be used in Support Services."
3. "At least 33 percent of the total SB 920 and/or SB 921 funds must be used towards Primary Prevention."
4. "At least 35 percent of the total SAPT funds must be used towards Alcohol programs."
5. "At least 35 percent of the total SAPT funds must be used towards Drug Programs."
6. "No more than 5 percent of the total DUI fees collected may be used in Support Services without a waiver from the Department."
7. "If a county's population exceeds 20,000, SGF may not be used in DUI programs."
8. "The amount of SAPT funds used towards Primary Prevention on lines 45 and 50 through 56 is less than the amount of the county's Prevention Set-Aside."
9. "No more than five percent of the total of line 68a may be used in Support Services."

The following messages appear in response to edits performed at the Provider entry level:

1. The total of lines 45 and 50 to 56 is checked to ensure that the total amount of SAPT Block Grant funds shown in these detail lines is reflected on lines 94 and 96.

   The edit appears as "The sum of lines 45 and 50 through 56 is not equal to Total Alcohol + Total Drug."

2. The State General Funds and Perinatal State General Funds and DMC overages (not Match to Medi-Cal) match requirement is checked for those counties with a population more than 100,000:

   a. "Ln81c + ln87c <> (ln41c+ ln41x + ln80c+ ln80x + ln90a)/9"

V. **Backup:**

This selection will copy the added files to the diskette, not the installation diskette transmitted with this package, which is to be returned to the Department.

VI. **Help:**

This document also resides within the Help section and operates the same from anywhere it is accessed within the program. It presents a main selection screen showing basic help instructions and specific selections for entering budget data and how to add a new provider.

VII. **Exit:**

Do not turn off the computer without exiting the program as your work could be damaged.

This selection will exit the NNA and DMC Cost Report program and returns to WINDOWS Program Manager. Should you encounter other problems for which you find no resolution, call Yue Kang, Computer Support, at (916) 323-0519. For questions regarding completion and submission of cost report documents, please contact your assigned Fiscal Management Branch analyst.

Paradox form "1998-99 NNA/DMC Cost V.0" form (Enclosure G, 87 pages): please get a copy from the Department of Alcohol and Drug Programs. Thank you.

A:\1998-99 NNA DMC Cost V.0 form (get a hard copy from ADP).doc:
8/26/99 9:15:00 AM

DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS
DRUG MEDI-CAL FISCAL DETAIL
REPORT OF EXPENDITURES AND REVENUES
FY 1998-99

SUMMARY

COUNTY _____ CONTRACT NUMBER _____
CONTRACTOR _____
CONTRACT PERIOD _____ MEDI-CAL PROV. NO. _____
DATE PREPARED _____ CADDS PROVIDER NO. _____
TYPE OF PROGRAM _____ (Specify as ODF Individual, ODF Group, DCH, RES)

[ ] ALCOHOL/DRUG [ ] PERINATAL

	A	B	C	D	E
CATEGORIES	TOTAL PROGRAM	PRIVATE PAY	MEDI-CAL	NNA/PUBLIC FUNDED	TOTAL MC/ NNA/PUBLIC
A. PERSONNEL SERVICES	0.00	0.00	0.00	0.00	0.00
B. DIRECT SERVICES	0.00	0.00	0.00	0.00	0.00
C. EQUIPMENT MATERIALS & SUPPLIES	0.00	0.00	0.00	0.00	0.00
D. OTHER OPERATING EXPENSES	0.00	0.00	0.00	0.00	0.00
E. PROFESSIONAL & SPECIAL SERVICES	0.00	0.00	0.00	0.00	0.00
F. TRANSPORTATION	0.00	0.00	0.00	0.00	0.00
G. INDIRECT COSTS	0.00	0.00	0.00	0.00	0.00
G1. COUNTY ADMINISTRATION	0.00		0.00		0.00
TOTAL GROSS COSTS	$0.00	$0.00	$0.00	$0.00	$0.00
REVENUES					
H. PARTICIPANT FEES	0.00				0.00
I. INSURANCE, MEDICARE, & OTHER THIRD PARTY	0.00				0.00
J. CONTRACTS & GRANTS (SPECIFY)					
J1. COUNTY - FEDERAL/STATE/COUNTY (NON-PERI)	0.00				0.00
J2. COUNTY - FEDERAL/STATE/COUNTY (PERINATAL)	0.00				0.00
J3. COUNTY/STATE - FED/STATE MEDI-CAL (NON-PERI)	0.00				0.00
J4. COUNTY/STATE - FED/STATE MEDI-CAL (PERINATAL)	0.00				0.00
J5. FEDERAL/STATE - DIRECT CONTRACT	0.00				0.00
J6. MINOR CONSENT	0.00				0.00
J7.	0.00				0.00
J8.	0.00				0.00
K. OTHER (SPECIFY)	0.00				0.00
K1. TCM/MAC (FEDERAL SHARE)	0.00				0.00
K2. PROVIDER UNRESTRICTED FUNDS	0.00				0.00
K3. COUNTY UNRESTRICTED FUNDS	0.00				0.00
TOTAL REVENUES	0.00	0.00	0.00	0.00	0.00
NET COSTS (GROSS COSTS LESS LINES H,I,K)	0.00	0.00	0.00	0.00	0.00
UNITS OF SERVICE					
L. INDIVIDUAL FACE TO FACE VISITS	0				0
M. GROUP FACE TO FACE VISITS	0				0
N. DAYCARE DAY	0				0
O. RESIDENTIAL DAY	0				0
P. OTHER (Specify) - MINOR CONSENT	0				0
P1.	0				0
Q. TOTAL UNITS OF SERVICE	0	0	0	0	0
R. GROUP SESSIONS	0				0
S. STAFF HOURS (DIRECT SVCS - COUNSELING, MEDICAL, ETC.)	0				0
T. COST PER UNIT OF SERVICE (UNITS) (GROSS COSTS/LINE Q)	$0.00	$0.00	$0.00	$0.00	$0.00
U. COST PER STAFF HOUR (GROSS COSTS/LINE S)	$0.00	$0.00	$0.00	$0.00	$0.00

DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS
DRUG MEDI-CAL FISCAL DETAIL
REPORT OF EXPENDITURES AND REVENUES
FY 1998-99

COUNTY	0	CONTRACT NUMBER	0
CONTRACTOR	0		
CONTRACT PERIOD	0	MEDI-CAL PROV. NO.	0
DATE PREPARED	0	CADDS PROVIDER NO.	0
TYPE OF PROGRAM	0	(Specify as ODF Individual, ODF Group, DCH, RES)	

CATEGORIES	TOTAL PROGRAM	PRIVATE PAY	MEDI-CAL	NNA/PUBLIC FUNDED	TOTAL MC/ NNA/PUBLIC
PERSONNEL SERVICES					
Salaries & Wages	0.00				0.00
Employee Benefits	0.00				0.00
TOTAL PERSONNEL SERVICES	0.00	0.00	0.00	0.00	0.00
DIRECT SERVICES					
Clothing & Personal Supplies	0.00				0.00
Food	0.00				0.00
Laundry Services & Supplies	0.00				0.00
Pharmaceutical	0.00				0.00
Other (Specify)	0.00				0.00
	0.00				0.00
	0.00				0.00
SUBTOTAL DIRECT SERVICES	0.00	0.00	0.00	0.00	0.00
EQUIPMENT, MATERIALS & SUPPLIES					
Depreciation-Equipment	0.00				0.00
Maintenance-Equipment	0.00				0.00
Medical, Dental, and Labratory Supplies	0.00				0.00
Membership Dues	0.00				0.00
Rents & Leases Equipment	0.00				0.00
Small Tools & Instruments	0.00				0.00
Training	0.00				0.00
Other (Specify)	0.00				0.00
	0.00				0.00
	0.00				0.00
SUBTOTAL EQUIPMENT, MATERIALS & SUPPLIES	0.00	0.00	0.00	0.00	0.00
OTHER OPERATING EXPENSES					
Communications	0.00				0.00
Depreciation-Structures & Improvements	0.00				0.00
Household Expenses	0.00				0.00
Insurance	0.00				0.00
Interest Expense	0.00				0.00
Leased Property Maintenance, Structures Improvements & Grounds	0.00				0.00
Maintenance-Structures, Improvements & Grounds	0.00				0.00
Miscellaneous Expense	0.00				0.00
Office Expense	0.00				0.00

Filename: 7895FORMULA.XLS

DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS
DRUG MEDI-CAL FISCAL DETAIL
REPORT OF EXPENDITURES AND REVENUES
FY 1998-99

COUNTY	0	CONTRACT NUMBER	0
CONTRACTOR	0		
CONTRACT PERIOD	0	MEDI-CAL PROV. NO.	0
DATE PREPARED	0	CADDS PROVIDER NO.	0
TYPE OF PROGRAM	0	(Specify as ODF Individual, ODF Group, DCH, RES)	

CATEGORIES	TOTAL PROGRAM	PRIVATE PAY	MEDI-CAL	NNA/PUBLIC FUNDED	TOTAL MC/ NNA/PUBLIC
OTHER OPERATING EXPENSES (Cont'd)					
Publications and Legal Notices	0.00				0.00
Rents & Leases-Land, Structures & Improvements	0.00				0.00
Taxes & Licenses	0.00				0.00
Drug Screenings & Other Testing	0.00				0.00
Utilities	0.00				0.00
Other (Specify)	0.00				0.00
	0.00				0.00
	0.00				0.00
SUBTOTAL OTHER OPERATING EXPENSES	0.00	0.00	0.00	0.00	0.00
PROFESSIONAL & SPECIAL SERVICES	0.00				0.00
TRANSPORTATION					
Transportation	0.00				0.00
Travel	0.00				0.00
Gas, Oil, & Maintenance - Vehicles	0.00				0.00
Rents & Leases-Vehicles	0.00				0.00
Depreciation-Vehicles	0.00				0.00
SUBTOTAL TRANSPORTATION	0.00	0.00	0.00	0.00	0.00
TOTAL NONPERSONNEL	0.00	0.00	0.00	0.00	0.00
Indirect Costs	0.00				0.00
PROVIDER TOTAL	$0.00	$0.00	$0.00	$0.00	$0.00
COUNTY ADMINISTRATION TOTAL	$0.00				$0.00
OVERALL TOTAL	$0.00	$0.00	$0.00	$0.00	$0.00
DIRECT COSTS (Only if both NNA and D/MC funding is identified)					

Filename: 7895FORMULA.xls

INSTRUCTIONS FOR DRUG MEDI-CAL FISCAL DETAIL
REPORT OF EXPENDITURES AND REVENUES
FY 1998-99

ADP Form #7895 (ODF Individual, ODF Group, DCH, RES)

This form will be completed for each provider of Medi-Cal services by type of treatment program (ODF Individual, ODF Group, DCH, RES). If a provider operates more than one type of treatment program (i.e., ODF and DCH, etc.), complete a separate report form for each treatment program. For County operated programs, prepare this form for each program.

NOTE: The "FY 1998-99 DMC Cost Report Forms" diskette contains the file, which includes the formulas for this form. The EXCEL filename is 89-7895FORMULA.XLS. Do not enter information in the cells where a "0" is located. These areas will automatically be calculated.

For ODF treatment, pages 1, 2, and 3 must be completed on an annual basis but separately for ODF Individual and ODF Group.

HEADING: Enter the County Name, Contractor, Contract Number, Contract Period, Medi-Cal Provider Number (billing number), CADDS Provider Number, Type of Program, and Date Prepared.

COLUMN INSTRUCTIONS:

Column A:	Enter total costs, revenues, and units of service of Columns B, C, and D for all lines.
Column B thru D:	Enter total costs for each category from pages 2 and 3. Obtain the revenues and units of service from the Provider's records.
Column E:	Enter total of costs, revenues, and units of service of Columns C and D for all lines.

LINE INSTRUCTIONS:

Line G1:	For contract and county operated programs, the county will enter allowable county administration. Allowable county administration costs pertaining to this line are only for the costs associated with utilization review, billing and training. (See Page 3 of instructions below for the report of other county administrative costs).
Total Gross Costs:	Enter total amounts applicable to each of Columns B, C, D, and E.
Lines H and I:	Enter total amounts applicable to each cost center.
Line J:	Enter totals of the funding sources listed for each cost center. For county-operated programs, enter all funding sources in the appropriate line.
Line K:	Enter total amounts applicable to each cost center.
Total Revenues:	Enter total amounts of all revenues (Lines H through K).
Net Costs:	Subtract Total Gross Costs by Lines H, I, and K for each cost center.
Lines L thru P:	Enter the total amounts applicable to each cost center.
Line Q:	Enter total amounts of all units (Lines L through P).
Line R:	Enter the total amount of sessions:
Line S:	Enter the total direct service staff hours (counseling, medical, etc) applicable to each cost center.
Line T:	Compute the cost per unit of service by dividing Total Gross Costs by Line Q (Total Units of Service).
Line U:	Computer the cost per staff hour by dividing Total Gross Costs by Line S (Staff Hours).

PAGES 2 AND 3: These costs provide a recording of the trail balance expense accounts from the provider's accounting books and records under the major categories listed.

Enter the costs, by line item, for each cost center. Column A will be total amount of Columns B, C, and D. Column E will be total of Columns C and D. Enter subtotals for each category in the appropriate lines.

Enter the total Direct Costs associated with NNA and DMC (only applicable if both funding sources are identified). These amounts are then entered on ADP Form 7990 on Line H under Columns 2 and 3 in the Adjustment of Total Cost section.

PAGE 3: Indirect (Administrative and Program) Costs:

For **non-county providers**, this line includes all administrative and program indirect costs.

For **county operated providers**, this line includes indirect program (treatment and other indirect administrative costs such as County A-87 overhead, Health and/or Mental Health Department, and Alcohol and Drug Program administrative costs. The allowable administrative costs for **utilization review, billing, and training**, must be reported on Line G1 on Page 1.

Note: Since ODF services consists of individual and group activities, costs must be allocated using "Staff Hours" as the basis.

Filename: G:\GROUPS3\FM\COST8-9\89-7895 Instructions.doc (7/99)

INSTRUCTIONS FOR DRUG MEDI-CAL FISCAL DETAIL
REPORT OF EXPENDITURES AND REVENUES
FY 1998-99

ADP Form #7895M (NTP and NAL)

This form will be completed for each provider of Medi-Cal services by type of treatment program (NTP or NAL). If a provider operates more than one type of treatment program, complete a separate report form for each treatment program. For County operated programs, prepare this form for each program.

NOTE: The "FY 1998-99 DMC Cost Report Forms" diskette contains the file, which includes the formulas for this form. The EXCEL filename is 89-7895MFORMULA.XLS. Do not enter information in the cells where a "0" is located. These areas will automatically be calculated.

HEADING: Enter the County Name, Contractor, Contract Number, Contract Period, Medi-Cal Provider Number (billing number), CADDS Provider Number, Type of Program, and Date Prepared.

COLUMN INSTRUCTIONS:

Column A:	Enter total costs, revenues, and units of service of Columns B, C, D, and E for all lines.
Column B thru E:	Enter total costs for each category from pages 2 and 3. Obtain the revenues and units of service from the Provider's records.
Column F:	Enter total of costs, revenues, and units of service of Columns D and E for all lines.
Column G:	Enter total of costs, revenues, and units of service of Columns C and F for all lines.

LINE INSTRUCTIONS:

Line G1:	For contract and county operated programs, the county will enter allowable county administration. Allowable county administration costs pertaining to this line are only for the costs associated with utilization review, billing and training. (See Page 3 of instructions below for the report of other county administrative costs).
Total Gross Costs:	Enter total amounts applicable to each of Columns B, C, D, and E.
Lines H and I:	Enter total amounts applicable to each cost center.
Line J:	Enter totals of the funding sources listed for each cost center. For county-operated programs, enter all funding sources in the appropriate line.
Line K:	Enter total amounts applicable to each cost center.
Total Revenues:	Enter total amounts of all revenues (Lines H through K).
Net Costs:	Subtract Total Gross Costs by Lines H, I, and K for each cost center.
Lines L:	Enter the number of Face to Face visits for Naltrexone ONLY for each cost center.
Line M1:	Enter the number of doses for Methadone for each cost center.
Line M2:	Enter the number of total milligrams for Methadone for each cost center.
Line M3:	Enter the number of total doses for LAAM for each cost center.
Line M4:	Enter the number of total milligrams for LAAM for each cost center.
Line M5:	Enter the number of total Individual Counseling Sessions (# of 10-minute increments) for each cost center.
Line M6:	Enter the number of total Group Counseling Sessions (# of 10-minute increments) for each cost center.
Line N:	Enter the Cost Per Unit – Naltrexone Only (Total Gross Costs divided by Line L) for each cost center.

PAGES 2 AND 3: These costs provide a recording of the trail balance expense accounts from the provider's accounting books and records under the major categories listed.

Enter the costs, by line item, for each cost center. Column A will be total amount of Columns B, C, D, and E. Column F will be total of Columns D and E. Column G will be the total amount of Columns C and F. Enter subtotals for each category in the appropriate lines.

For NAL only, enter the total Direct Costs associated with NNA and DMC (only applicable if both funding sources are identified). These amounts are then entered on ADP Form 7990 on Line H under Columns 2 and 3 in the Adjustment of Total Cost section.

PAGE 3: Indirect (Administrative and Program) Costs:

For **non-county providers**, this line includes all administrative and program indirect costs. For **county operated providers**, this line includes indirect program (treatment and other indirect administrative costs such as County A-87 overhead, Health and/or Mental Health Department, and Alcohol and Drug Program administrative costs. The allowable administrative costs for **utilization review, billing, and training**, must be reported on Line G1 on Page 1.

COST REPORT FUNDING APPLICATION WORKSHEET - FY 1998-99

County:
Contractor: CADDS #: DMC #:
Modality: ODF - GROUP CHECK ONE: [___] Alcohol/Drug [___] Perinatal

Line #	Funding Sources	NNA Amount	DMC Amount	Total
40	Drug Medi-Cal (Fed Share Only) Fed Cat #93.778			0
40a	Perinatal Medi-Cal (Fed Share Only) Fed Cat #93.778			0
40b	Perinatal (PTEP) Match to Medi-Cal			0
41c	Perinatal State General Fund			0
41g	Perinatal Treatment Network Services SGF			0
41h	Perinatal Substance Abuse Treatment SGF			0
41x	Perinatal State General Fund - Backfill			0
46	Parolee Services Project			0
50	SAPT - Discretionary Fed Cat #93.959			0
51	HIV Set-Aside Fed Cat #93.959			0
52	SAPT - Perinatal Set-Aside Fed Cat #93.959			0
56	SAPT Special Projects Fed Cat #93.959			0
56a	SAPT Discretionary One-Time Fed Cat #93.959			0
57	SSI / DA / A Fed Cat #93.959			0
70	State General Fund - Match to Medi-Cal			0
79	TCM/MAA			0
80	Non County Revenue			0
80c	State General Fund - Regular Alcohol / Drug			0
80x	State General Fund - Backfill			0
81c	Required County Match (Alcohol/Drug or Perinatal)			0
82	County Fund - Other			0
82a	Provider Unrestricted Funds			0
82b	County Unrestricted Funds			0
83	Excess fees Spent			0
84	Fees / DMC Share of Costs			0
85	Insurance			0
86	PC 1463.45 - SB 920 HS 11372.7 - SB 921			0
87	Statham			0
87c	Statham - Match (Alcohol/Drug or Perinatal)			0
90a	Obligated Unexpended SGF Prior FY			0
	Total:	0	0	0
EDITS	FUNDING NEEDED	0	0	0
		OKAY	OKAY	OKAY

Direct DMC Costs:
Direct NNA Costs:
DMC County Administration
Group Sessions:
Combined Cost Per Unit: 0.00 Hours
DMC Maximum Rate 32.50
DMC Costs 0
DMC Maximum Allowable 0
DMC Excess Costs 0
NNA Costs 0

SIGNATURE OF COUNTY REPRESENTATIVE

Filename: ODFGFUND.WK1 (8/99)

NNA Hours: **Staff Hours**
DMC Units: **Individuals**
NNA Units: **Individuals**
DMC Cost Per Unit: 0.00
NNA Cost Per Unit: 0.00 Hours

Total Costs

EDITS

SAPT

INCREASE LINES 41c,41g, 41h, 80,80c, 81c, 82, 87c,90a
BY

REDUCE LINES 46,50,51,52,56, 56a,57
BY

NNA

REDUCE NNA LINES 41c,41g,41h, 80,80c, 81c,82, 87c,90a
BY

INCREASE DMC LINES 80, 81c, 82, 82a, 82b, 87c,90a
BY

DMC

INCREASE NNA LINES 41c,41g,41h, 80,80c, 81c, 87c,90a
BY

DECREASE DMC LINES 80, 81c, 82, 82a, 82b, 87c,90a
BY

INSTRUCTIONS FOR
COST REPORT FUNDING APPLICATION WORKSHEET
For Outpatient Drug Free – Group Counseling (ODF-G) Programs
That have both DMC and NNA Funding
FY 1998-99

HEADING: Enter County Name, Provider/Contractor Name, CADDS 6-digit number and DMC 4 digit number. Also, identify whether the form is for Alcohol/Drug (non-Perinatal) Services or Perinatal Services.

NOTE: The "FY 1998-99 Cost Report Forms" diskette contains the file which includes this form. The EXCEL filename is ODFGFUND.XLS. Do not enter information in the cells where a "0" is located. These areas will be automatically calculated.

THIS FORM IS ONLY REQUIRED FOR THOSE PROVIDERS THAT HAVE BOTH NNA AND DMC FUNDING FOR ODF-GROUP SERVICES.

DATA ENTRY INSTRUCTIONS:

Unit/Cost Information (Top Right Hand Corner):
- **NNA Hours**: Enter the number of NNA Staff Hours.
- **DMC Units**: Enter the number of DMC units of service for Individuals.
- **NNA Units**: Enter the number of NNA units of service for Individuals.
- **Total Costs**: Enter the total cost of the program (both NNA and DMC costs).

Cost Information (Bottom Left Hand Corner):
- **Direct DMC Costs**: If applicable, enter the direct DMC costs.
- **Direct NNA Costs**: If applicable, enter the direct NNA costs.
- **DMC County Administration**: If applicable, enter the DMC County Administration costs.
- **Group Sessions**: Enter the number of total group sessions that were provided during the fiscal year.

DMC MAXIMUM RATE: Depending on if the service is for Alcohol/Drug or Perinatal, the rate will need to be reflective of the correct rate (see Rate Chart). Change the rate according to the type of service.

Based on the information entered for staff hours, units, total costs, direct costs, DMC county administration costs, and the number of group sessions, the system will then identify how much funding is needed for both NNA and DMC.

NNA Amount and DMC Amount
- For each funding column, enter the cost amount by funding line.
- Based on the amounts identified in each funding line within each column, the system will identify if you have entered the correct amount of funding under NNA and DMC. If the correct total funding amounts have been entered, an "OKAY" message will be identified. If the total funding amounts do not match, an "ERROR" message will appear.

EDITS
- **SAPT Edits**: Based on the amount of funding that is identified within the NNA and DMC amount columns and by funding lines, the system will determine if non-SAPT costs were placed within the SAPT funding lines. This edit will identify how much funding needs to be reduced from the SAPT funding lines and how much needs to be added to the non-SAPT funding lines.

- **NNA Edits**: Based on the amount of funding that is identified within the NNA and DMC amount columns and by funding line, the system will determine if DMC costs were placed within the NNA columns. This edit will identify how much funding needs to be reduced from the NNA columns and how much needs to be added to the DMC columns.

- **DMC Edits**: Based on the amount of funding that is identified within the NNA and DMC amount columns and by funding line, the system will determine if NNA costs were placed within the DMC columns. This edit will identify how much funding needs to be reduced from the DMC columns and how much needs to be added to the NNA columns.

Once all the edits have been eliminated and all three "OKAY" messages appear, enter the amounts on the Paradox diskette.

THE FORM MUST BE COMPLETED (WITH ALL EDITS ELIMINATED AND ALL MESSAGES 'OKAY"), SIGNED BY THE COUNTY REPRESENTATIVE, AND SUBMITTED WITH THE COST REPORT.

COST REPORT FUNDING APPLICATION WORKSHEET - FY 1998-99

County:
Contractor: CADDS #: DMC #:
Modality: ODF - INDIVIDUAL CHECK ONE: [___] Alcohol/Drug [___] Perinatal

Line #	Funding Sources	NNA Amount	DMC Amount	Total
40	Drug Medi-Cal (Fed Share Only) Fed Cat #93.778			0
40a	Perinatal Medi-Cal (Fed Share Only) Fed Cat #93.778			0
40b	Perinatal (PTEP) Match to Medi-Cal			0
41c	Perinatal State General Fund			0
41g	Perinatal Treatment Network Services SGF			0
41h	Perinatal Substance Abuse Treatment SGF			0
41x	Perinatal State General Fund - Backfill			0
46	Parolee Services Project			0
50	SAPT - Discretionary Fed Cat #93.959			0
51	HIV Set-Aside Fed Cat #93.959			0
52	SAPT - Perinatal Set-Aside Fed Cat #93.959			0
56	SAPT Special Projects Fed Cat #93.959			0
56a	SAPT Discretionary One-Time Fed Cat #93.959			0
57	SSI / DA / A Fed Cat #93.959			0
70	State General Fund - Match to Medi-Cal			0
79	TCM/MAA			0
80	Non County Revenue			0
80c	State General Fund - Regular Alcohol / Drug			0
80x	State General Fund - Backfill			0
81c	Required County Match (Alcohol/Drug or Perinatal)			0
82	County Fund - Other			0
82a	Provider Unrestricted Funds			0
82b	County Unrestricted Funds			0
83	Excess fees Spent			0
84	Fees / DMC Share of Costs			0
85	Insurance			0
86	PC 1463.45 - SB 920 HS 11372.7 - SB 921			0
87	Statham			0
87c	Statham - Match (Alcohol/Drug or Perinatal)			0
90a	Obligated Unexpended SGF Prior FY			0
	Total:	0	0	0
EDITS	FUNDING NEEDED	0	0	0
		OKAY	OKAY	OKAY

Direct DMC Costs:
Direct NNA Costs:
DMC County Administration

Combined Cost Per Unit: 0.00 Hours
DMC Maximum Rate 61.73
DMC Costs 0
DMC Maximum Allowable 0
DMC Excess Costs 0
NNA Costs 0

Filename: ODFIFUND.WK1 (8/99)

NNA Hours: **Staff Hours**
DMC Units: **Individuals**
NNA Units: **Individuals**
DMC Cost Per Unit: 0.00
NNA Cost Per Unit: 0.00 Hours

Total Costs

EDITS

SAPT

INCREASE LINES 41c,41g, 41h, 80,80c, 81c, 82, 87c,90a
BY

REDUCE LINES 46,50,51,52,56, 56a,57
BY

NNA

REDUCE NNA LINES 41c,41g,41h, 80,80c, 81c,82, 87c,90a
BY

INCREASE DMC LINES 80, 81c, 82, 82a, 82b, 87c,90a
BY

DMC

INCREASE NNA LINES 41c,41g,41h, 80,80c, 81c, 87c,90a
BY

_____
SIGNATURE OF COUNTY REPRESENTATIVE

DECREASE DMC LINES 80, 81c, 82, 82a, 82b, 87c,90a
BY

INSTRUCTIONS FOR
COST REPORT FUNDING APPLICATION WORKSHEET
For Outpatient Drug Free – Individual Counseling (ODF-I) Programs
That have both DMC and NNA Funding
FY 1998-99

HEADING: Enter County Name, Provider/Contractor Name, CADDS 6-digit number and DMC 4 digit number. Also, identify whether the form is for Alcohol/Drug (non-Perinatal) Services or Perinatal Services.

NOTE: The "FY 1998-99 Cost Report Forms" diskette contains the file which includes this form. The EXCEL filename is ODFIFUND.XLS. Do not enter information in the cells where a "0" is located. These areas will be automatically calculated.

THIS FORM IS ONLY REQUIRED FOR THOSE PROVIDERS THAT HAVE BOTH NNA AND DMC FUNDING FOR ODF-INDIVIDUAL SERVICES.

DATA ENTRY INSTRUCTIONS:

Unit/Cost Information (Top Right Hand Corner):
- **NNA Hours**: Enter the number of NNA Staff Hours.
- **DMC Units**: Enter the number of DMC units of service for Individuals.
- **NNA Units**: Enter the number of NNA units of service for Individuals.
- **Total Costs**: Enter the total cost of the program (both NNA and DMC costs).

Cost Information (Bottom Left Hand Corner):
- **Direct DMC Costs**: If applicable, enter the direct DMC costs.
- **Direct NNA Costs**: If applicable, enter the direct NNA costs.
- **DMC County Administration**: If applicable, enter the DMC County Administration costs.

DMC MAXIMUM RATE: Depending on if the service is for Alcohol/Drug or Perinatal, the rate will need to be reflective of the correct rate (See Rate Chart). Change the rate according to the type of service.

Based on the information entered for staff hours, units, total costs, direct costs, DMC county administration costs, the system will then identify how much funding is needed for both NNA and DMC.

NNA Amount and DMC Amount
- For each funding column, enter the cost amount by funding line.
- Based on the amounts identified in each funding line within each column, the system will identify if you have entered the correct amount of funding under NNA and DMC. If the correct total funding amounts have been entered, an "OKAY" message will be identified. If the total funding amounts do not match, an "ERROR" message will appear.

EDITS
- **SAPT Edits**: Based on the amount of funding that is identified within the NNA and DMC amount columns and by funding lines, the system will determine if non-SAPT costs were placed within the SAPT funding lines. This edit will identify how much funding needs to be reduced from the SAPT funding lines and how much needs to be added to the non-SAPT funding lines.

- **NNA Edits**: Based on the amount of funding that is identified within the NNA and DMC amount columns and by funding line, the system will determine if DMC costs were placed within the NNA columns. This edit will identify how much funding needs to be reduced from the NNA columns and how much needs to be added to the DMC columns.

- **DMC Edits**: Based on the amount of funding that is identified within the NNA and DMC amount columns and by funding line, the system will determine if NNA costs were placed within the DMC columns. This edit will identify how much funding needs to be reduced from the DMC columns and how much needs to be added to the NNA columns.

Once all the edits have been eliminated and all three "OKAY" messages appear, enter the amounts on the Paradox diskette.

THE FORM MUST BE COMPLETED (WITH ALL EDITS ELIMINATED AND ALL MESSAGES 'OKAY"), SIGNED BY THE COUNTY REPRESENTATIVE, AND SUBMITTED WITH THE COST REPORT.

COST REPORT FUNDING APPLICATION WORKSHEET - FY 1998-99

County: _____

Contractor: _____ CADDS #: _____ DMC #: _____

Modality: DCH CHECK ONE: [___] Alcohol/Drug [___] Perinatal

Line #	Funding Sources	NNA Amount	DMC Amount	Total
40	Drug Medi-Cal (Fed Share Only) Fed Cat #93.778			0
40a	Perinatal Medi-Cal (Fed Share Only) Fed Cat #93.778			0
40b	Perinatal (PTEP) Match to Medi-Cal			0
41c	Perinatal State General Fund			0
41g	Perinatal Treatment Network Services SGF			0
41h	Perinatal Substance Abuse Treatment SGF			0
41x	Perinatal State General Fund - Backfill			0
46	Parolee Services Project			0
50	SAPT - Discretionary Fed Cat #93.959			0
51	HIV Set-Aside Fed Cat #93.959			0
52	SAPT - Perinatal Set-Aside Fed Cat #93.959			0
56	SAPT Special Projects Fed Cat #93.959			0
56a	SAPT Discretionary One-Time Fed Cat #93.959			0
57	SSI / DA / A Fed Cat #93.959			0
70	State General Fund - Match to Medi-Cal			0
79	TCM/MAA			0
80	Non County Revenue			0
80c	State General Fund - Regular Alcohol / Drug			0
80x	State General Fund - Backfill			0
81c	Required County Match (Alcohol/Drug or Perinatal)			0
82	County Fund - Other			0
82a	Provider Unrestricted Funds			0
82b	County Unrestricted Funds			0
83	Excess fees Spent			0
84	Fees / DMC Share of Costs			0
85	Insurance			0
86	PC 1463.45 - SB 920 HS 11372.7 - SB 921			0
87	Statham			0
87c	Statham - Match (Alcohol/Drug or Perinatal)			0
90a	Obligated Unexpended SGF Prior FY			0
	Total:	0	0	0
EDITS	FUNDING NEEDED	0	0	0
		OKAY	OKAY	OKAY

Direct DMC Costs: _____

Direct NNA Costs: _____

DMC County Administration _____

Combined Cost Per Unit: 0.00 **Daycare Day**

DMC Maximum Rate 65.95

DMC Costs 0

DMC Maximum Allowable 0

DMC Excess Costs 0

NNA Costs 0

Filename: DCHFUND.WK1 (8/99)

_____

SIGNATURE OF COUNTY REPRESENTATIVE

DMC Units: _____ **Daycare Day**

NNA Units: _____ **Daycare Day**

DMC Cost Per Unit: 0.00 **Daycare Day**

NNA Cost Per Unit: 0.00 **Daycare Day**

Total Costs _____

EDITS

SAPT

INCREASE LINES 41c,41g, 41h, 80,80c, 81c, 82, 87c,90a

BY

REDUCE LINES 46,50,51,52,56, 56a,57

BY

NNA

REDUCE NNA LINES 41c,41g,41h, 80,80c, 81c,82, 87c,90a

BY

INCREASE DMC LINES 80, 81c, 82, 82a, 82b, 87c,90a

BY

DMC

INCREASE NNA LINES 41c,41g,41h, 80,80c, 81c, 87c,90a

BY

DECREASE DMC LINES 80, 81c, 82, 82a, 82b, 87c,90a

BY

INSTRUCTIONS FOR
COST REPORT FUNDING APPLICATION WORKSHEET
For Day Care Habilitative (DCH) Programs
That have both DMC and NNA Funding
FY 1998-99

HEADING: Enter County Name, Provider/Contractor Name, CADDS 6-digit number and DMC 4 digit number. Also, identify whether the form is for Alcohol/Drug (non-Perinatal) Services or Perinatal Services.

NOTE: The "FY 1998-99 Cost Report Forms" diskette contains the file which includes this form. The EXCEL filename is DCHFUND.XLS. Do not enter information in the cells where a "0" is located. These areas will be automatically calculated.

THIS FORM IS ONLY REQUIRED FOR THOSE PROVIDERS THAT HAVE BOTH NNA AND DMC FUNDING FOR DCH SERVICES.

DATA ENTRY INSTRUCTIONS:

Unit/Cost Information (Top Right Hand Corner):
- **DMC Units**: Enter the number of DMC units of service of Daycare Days.
- **NNA Units**: Enter the number of NNA units of service of Daycare Days.
- **Total Costs**: Enter the total cost of the program (both NNA and DMC costs).

Cost Information (Bottom Left Hand Corner):
- **Direct DMC Costs**: If applicable, enter the direct DMC costs.
- **Direct NNA Costs**: If applicable, enter the direct NNA costs.
- **DMC County Administration**: If applicable, enter the DMC County Administration costs.

DMC MAXIMUM RATE: Depending on if the service is for Alcohol/Drug or Perinatal, the rate will be need to be reflective of the correct rate (see Rate Chart). Change the rate according to the type of Service.

Based on the information entered for units, total costs, direct costs, DMC county administration costs, the system will then identify how much funding is needed for both NNA and DMC.

NNA Amount and DMC Amount
- For each funding column, enter the cost amount by funding line.
- Based on the amounts identified in each funding line within each column, the system will identify if you have entered the correct amount of funding under NNA and DMC. If the correct total funding amounts have been entered, an "OKAY" message will be identified. If the total funding amounts do not match, an "ERROR" message will appear.

EDITS
- **SAPT Edits**: Based on the amount of funding that is identified within the NNA and DMC amount columns and by funding lines, the system will determine if non-SAPT costs were placed within the SAPT funding lines. This edit will identify how much funding needs to be reduced from the SAPT funding lines and how much needs to be added to the non-SAPT funding lines.

- **NNA Edits**: Based on the amount of funding that is identified within the NNA and DMC amount columns and by funding line, the system will determine if DMC costs were placed within the NNA columns. This edit will identify how much funding needs to be reduced from the NNA columns and how much needs to be added to the DMC columns.

- **DMC Edits**: Based on the amount of funding that is identified within the NNA and DMC amount columns and by funding line, the system will determine if NNA costs were placed within the DMC columns. This edit will identify how much funding needs to be reduced from the DMC columns and how much needs to be added to the NNA columns.

Once all the edits have been eliminated and all three "OKAY" messages appear, enter the amounts on the Paradox diskette.

THE FORM MUST BE COMPLETED (WITH ALL EDITS ELIMINATED AND ALL MESSAGES 'OKAY"), SIGNED BY THE COUNTY REPRESENTATIVE, AND SUBMITTED WITH THE COST REPORT.

DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS
DRUG MEDI-CAL FISCAL DETAIL
DRUG MEDI-CAL PROGRAM COST SUMMARY
FY 1998-99

COUNTY: _____ CONTRACT NUMBER _____
CONTRACTOR: _____
CONTRACT PERIOD: _____ MEDI-CAL PROV. NUMBER _____
DATE PREPARED: _____ CADDS PROVIDER NUMBER _____
TYPE OF PROGRAM: _____ (Specify as NAL, ODF Individual, ODF Group, DCH, RES)

CHECK EACH AREA THAT APPLIES (Alcohol/Drug and Perinatal must be submitted separately)
Alcohol/Drug (Non-Perinatal): [__] Regular Services [__] Minor Consent [__] EPSDT
Perinatal: [__] Regular Services [__] Minor Consent [__] EPSDT

ADJUSTMENT OF TOTAL COST

	CATEGORY	1 TOTAL PROVIDER COSTS	2 LESS DIRECT NNA COSTS	3 LESS DIRECT DMC COSTS	4 ADJUSTED PROGRAM COST	5	
	A. PERSONNEL SERVICES						
	B. DIRECT SERVICES						
	C. EQUIPMENT, MATERIAL, & SUPPLIES						
	D. OTHER OPERATION EXPENSES						
	E. PROFESSIONAL & SPECIAL SERVICES						
	F. TRANSPORTATION						
	G. INDIRECT COSTS						
	H. TOTAL COSTS						

MEDI-CAL PROVIDER COST CALCULATION

		ADJUSTED PROGRAM COST		TOTAL			
01	TOTAL SERVICE COSTS						01
02	TOTAL SERVICE UNITS						02
03	COST PER UNIT OF SERVICE						03
04	MAXIMUM ALLOWABLE UNIT RATE						04

DRUG MEDI-CAL (DMC) RECONCILIATION OF CLAIMS (UNITS)		TOTAL UNITS SUBMITTED	DENIED UNITS	ADJUSTED/ ERRONEOUS UNITS	TOTAL ADJUSTED UNITS		
04a	1st Reporting Period (7/1/98 through 9/30/98)						04a
04b	2nd Reporting Period (10/1/98 through 6/30/99)						04b
04c	Total Reporting Period (7/1/98 through 6/30/99)						04c

DRUG MEDI-CAL (DMC) UNITS OF SERVICE		TOTAL ADJUSTED UNITS		TOTAL ADJUSTED UNITS			
05	TOTAL DMC UNITS OF SERVICE						05
05a	DMC Units of Service - July thru September						05a
05b	DMC Units of Service - October thru June						05b
05c	DMC Minor Consent (non-Peri) Units - July thru June						05c

COST OF DRUG MEDI-CAL UNITS OF SERVICE							
09	COST - (Line 3 X Line 5)						09
10a	COUNTY MEDI-CAL ADMINISTRATION						10a
10b	DIRECT DMC COSTS						10b
11	TOTAL MEDI-CAL COSTS (Add Lines 9 + 10a + 10b)						11
12	TOTAL MEDI-CAL COST PER UNIT (line 11/line 5)						12
13	MAXIMUM ALLOWED (Line 4 X Line 5)				Federal Share	State Share	13
14	DRUG MEDI-CAL ALLOWED (Lesser of Lines 11 or 13)				51.23%	48.77%	14
14a	Allowed for July - Sep (5a X the lesser line 12 or 4)						14a
					51.55%	48.45%	
14b	Allowed for Oct - June (5b X the lesser line 12 or 4)						14b
						100%	
14c	Allowed (Non-Peri) Minor Consent (5c X the lesser 12 or 4)						14c
14d	Total of 14 a, 14b, & 14c						14d

REVENUE FROM DRUG MEDI-CAL UNITS OF SERVICE					50%	50%	
15	REVENUE						15

NET DRUG MEDI-CAL COSTS							
17	NET COST (Line 14d minus Line 15)						17
20	LESS: AMOUNT RECEIVED						20
21	BALANCE DUE (COUNTY) PROVIDER						21

INSTRUCTIONS FOR DRUG MEDI-CAL FISCAL DETAIL
DRUG MEDI-CAL PROGRAM COST SUMMARY
FY 1998-99

ADP FORM 7990 (NAL, ODF INDIVIDUAL, ODF GROUP, DCH, RES)

NOTE: The "FY 1998-99 DMC Cost Report Forms" diskette contains the file which includes this form. The EXCEL filename is 89-7990FORMULA.xls. Do not enter information in the cells where a "0" is located. These areas will be automatically calculated.

ADJUSTMENT OF TOTAL COST

HEADING: Enter the County Name, Contractor, Contract Number, Contract Period, Medi-Cal, and CADDS Provider Numbers, Prepared Date, and Type of Program.

NOTE: Submit a separate Form 7990 for each type of program. Also, check each applicable area that applies for either Regular (non-Perinatal) or Perinatal services.

COLUMN INSTRUCTIONS:

NOTE: The amounts identified under this area will be same for each component identified, i.e., Alcohol/Drug, Perinatal, Alcohol/Drug – Minor Consent, and Perinatal – Minor Consent, etc.

COLUMN 1: **For ODF and RES**: Enter total provider costs for each cost category from Page 1, Column C (Medi-Cal) of ADP Form 7895.
For DCH: Enter total provider costs for each category from Page 1, Column E (Total MC/NNA/Public) of ADP Form 7895.
For NAL: Enter total provider costs for each category from Page 1, Column G (Total Maintenance) of ADP Form 7895M.

COLUMN 2: Enter **Direct NNA** Costs – Enter total NNA direct costs. For example, under Perinatal Residential, the costs of room and board are not allowable under DMC; therefore, the costs are directly related to NNA.

COLUMN 3: Enter **Direct DMC** Costs – Enter total DMC direct costs. For example, a physician is hired to do physical exams for DMC clients only and not NNA clients; therefore, the cost of the physician is a direct cost to DMC only.

COLUMN 4: For each line, subtract Columns 2 and 3 from Column 1.

MEDI-CAL PROVIDER COST CALCULATION

COLUMN AND LINE INSTRUCTIONS:

NOTE: The amounts identified on Lines 01 through 04 under this area will be same for each component identified, i.e., Alcohol/Drug, Perinatal, Alcohol/Drug – Minor Consent, and Perinatal – Minor Consent, etc.

LINE 01: Enter the total of the Total Program Adjusted Cost column (Column 4 above – total of Lines A through G) in Columns 1 and 3.

LINE 02: **For ODF and RES**: Enter total service units in Columns 1 and 3 from Page 1, Column C, Line Q of ADP Form 7895.
For DCH: Enter total service units in Columns 1 and 3 from Page 1, Column E, Line Q of ADP Form 7895.
For NAL: Enter total service units in Columns 1 and 3 from Page 1, Column G, Line L of ADP Form 7895M.

LINE 03: Enter the cost per unit of service by dividing Line 01 by Line 02 for Columns 1 and 3.

LINE 04: Enter the maximum allowable unit rate in Columns 1 and 3.

LINE 04a: For the **1st Reporting Period,** for all treatment elements, except Minor Consent (non-Perinatal), report services provided from July 1 through September 30. For Minor Consent (non-Perinatal), report services provided from July 1 through June 30. Under Column 1, enter Total Units Submitted (all units submitted for processing during the first reporting period, regardless of status of suspended, approved, or denied). Under Column 2, enter Denied Units (units denied through the automated claims processing system which were not resubmitted for further processing). Under Column 3, enter Adjusted/Erroneous Units (units which were erroneous or adjusted by State Utilization monitors). Under Column 4, Subtract the sum of Denied Units and Adjusted/Erroneous Units from Total Units Submitted.

LINE 04b: For the **2nd Reporting Period,** for all treatment elements, except Minor Consent (non-Perinatal), report services provided from October 1 through June 30. Do not report Minor Consent (non-Perinatal) in this reporting period. Under Column 1, enter Total Units Submitted (all units submitted for processing during the second period, regardless of status of suspended, approved, or denied). Under Column 2, enter Denied Units (units denied through the automated claims processing system which were not resubmitted for further processing). Under Column 3, enter Adjusted/Erroneous Units (units which were erroneous or adjusted by State Utilization monitors). Under Column 4, Subtract the sum of Denied Units and Adjusted/Erroneous Units from Total Units Submitted.

LINE 04c: Add together Lines 04a and 04b for the total the units of service from both reporting periods. This total should match the total identified in Columns 1 and 3 of Line 05.

LINE 05: Is the TOTAL number of DMC service units that are applicable to the type of program identified. It should be the total of Lines 05a through 05c and should be equal to Column 4, line 04c.
This total should equal the total units of service from Page 1, Column C, Line Q, of ADP Form 7895 or for NAL from Column D, Line L, of ADP Form 7895M.

LINE 05a: Enter DMC units of service (regular and EPSDT) for the period July - September in Columns 1 and 3. These should equal Column 4, line 04a less minor consent.

LINE 05b: Enter DMC units of service (regular and EPSDT) for the period October - June in Columns 1 and 3. These should equal Column 4, line 04b less minor consent.

LINE 05c: Enter DMC units of service for minor consent (non-perinatal) for the period July – June in Columns 1 and 3.

LINE 09: Enter the cost of DMC units of service, Line 30 multiplied by Line 05, in Columns 1 and 3.

LINE 10a: Enter County DMC administration costs that are applicable to the type of program identified in Column 3. The total should equal the total amount County Administration from Page 1, Column C, Line G1, of ADP Form 7895. For Naltrexone, the amount should equal the County Administration from Page 1, Column D, Line G1 of ADP Form 7895M.

LINE 10b: Enter the total amount of Direct DMC costs as identified in Line H, Column 3 of the Adjustment of Total Cost portion of this form.

LINE 11: Enter the Total Medi-Cal cost. For Column 1, enter the amount from Line 09. For Column 3, enter the total of Lines 09 and 10a and 10b.

LINE 12: Enter total Medi-Cal cost per unit, Line 11 divided by Line 5.

LINE 13: Enter the maximum allowed cost of DMC units of service, Line 04 multiplied by Line 05, in Columns 1 and 3.

LINE 14: Enter the amount of allowable DMC costs in Columns 1 and 3. Enter the lesser of Line 11 or Line 13.

LINE 14a: Enter the cost of DMC allowed for July – September, Line 5a multiplied by the lesser of Line 4 or 12, in Columns 1 and 3. Enter the Federal share in Column 4 and the State share in Column 5, based on the percentage allowed for that period of 51.23% Federal and 48.77% State.

LINE 14b: Enter the cost of DMC allowed for October – June, Line 5b multiplied by the lesser of Line 4 or 12, in Columns 1 and 3. Enter the Federal share in Column 4 and the State share in Column 5, based on the percentage allowed for that period of 51.55% Federal and 48.45% State.

LINE 14c: Enter the cost of DMC allowed for July – June, Line 5c multiplied by the lesser of Line 4 or 12, in Columns 1 and 3. Enter the State share (100%) in Column 5.

LINE 15: Enter the revenue attributed to Federal DMC units of service (required co-payments) for Columns 1 and 3.

LINE 17: Enter the Net DMC costs, Line 14d minus Line 15, for Columns 1 and 3.

LINE 20: Enter the amount of reimbursement received from the county in Column 1.

LINE 21: Enter the balance due the county or provider, Line 17 minus Line 20, in Column 1.

Note: Do not complete Lines 20 or 21 for county-operated programs.

INSTRUCTIONS FOR ODF HOURS WORKSHEET (ODFHR) and PERINATAL ODF WORKSHEET (PODFHR)

The ODF **Hours** Worksheet (ODFHR) may be used to develop the ODF budget and cost report. There are separate worksheets for D/MC and Perinatal Medi-Cal. Entries are only required in the blank cells that are highlighted in yellow (shaded on hard copy). With the exception of Lines 15 and 18, all data entry is done on page 1. All non-highlighted cells contain formulas. **Please do not change any of the formulas.**

Providers will maintain the following documentation:

1. Group Sessions
   (a) Group rosters by client name showing the payor for each client.
   (b) Date, start time, and end time of the session.
   (c) Counselor's name.

2. Individual Sessions
   (a) Counselor's calendar, schedule, etc. which indicates the name of the client, date, start time, and end time of every individual counseling session.

3. All documentation must be traceable to client records.

The following are Form ODFHR instructions:

Page 1

LINE 1 TOTAL GROSS COSTS – **Enter** the **total costs** to operate the program in Column D. These costs must be traceable to the provider's accounting records.

LINE 2 ADJUSTMENTS FOR MEDI-CAL UNREIMBURSABLE COSTS – **Enter** the costs of **services, that are program requirements**, but are not allowable within the Utilization Control Plan in Column A and Column C. The Medi-Cal share of such costs must be identified and entered as a cost chargeable to the NNA and/or Private cost center.

(For example: Some Perinatal required services, such as child care (baby sitting), is a Perinatal requirement that is not Medi-Cal reimbursable. Also, certain SAPT Block Grant requirements for HIV and TB would not be Medi-Cal reimbursable.)

LINE 3 ADJUSTMENTS FOR DIRECT COSTS – **Enter** the costs of **services** that are applicable to a single cost center.

(For example: URC Costs are a direct cost only to the Medi-Cal cost center. The amount of such costs would be indicated in the Medi-Cal cost center).

LINE 4 TOTAL ADJUSTMENTS FOR MEDI-CAL UNREIMBURSABLE AND DIRECT COSTS – **Computed by formula.** Total of all Medi-Cal unreimbursable and direct costs entered in Lines 1 and 2.

LINE 5 ADJUSTED GROSS COSTS TO BE DISTRIBUTED – **Computed by formula.** Total gross costs (LINE 1) minus total Medi-Cal unreimbursable and direct costs (LINE 4). These costs represent equal services to all clients.

LINE 6 COUNTY MEDI-CAL ADMINISTRATION – **Enter** the amount of county administration (URC, billing, and training) incurred by the county. These costs must be supported by the county's accounting records.

LINE 7 TOTAL COSTS (PROGRAM AND COUNTY MEDI-CAL ADMINISTRATION) – **Computed by formula.** Adds total adjustments for Medi-Cal unreimbursable and direct costs (LINE 4), adjusted gross costs to be distributed (LINE 5), and county Medi-Cal administration (LINE 6).

LINE 8 TOTAL GROUP SESSIONS FOR THE YEAR – **Enter** the number of group sessions held by the provider. This information must be documented by the provider. To Column "A", Line "N", Form 7895ODFAVG or 7895PODFAVG.

(For example, if a provider holds 2 group sessions a day, 5 days a weeks, 52 weeks a year – this number will be 520).

LINE 9 NUMBER OF GROUP SESSIONS BY COST CENTER – For each cost center, **enter** the number of sessions in which at least one (1) of the cost center's clients participated. This information must be documented by the provider. To Columns B, C, and D, Line "H1", Form 7895ODFAVG or 7895PODFAVG.

(For example, of the 520 total groups sessions (LINE 8 example), review of the group rosters indicated private clients participated in 120 groups, Medi-Cal clients in 490 groups, and NNA clients in 410 groups – enter 120 (Private), 490 (Medi-Cal), and 410 (NNA).

NOTE: Since most group sessions contain participants from all cost centers, the number of group sessions will not add up to the total on Line 8.

LINE 10 TOTAL GROUP FACE TO FACE VISITS (GROUP UNITS OF SERVICE) – **Enter** the actual number of clients who participated in each of the group sessions. This information must be documented by the provider. No comparable line in ODF/7895OPN. These forms require detailed entries by funding source.

See Page 14 of the Drug Program Fiscal Systems Manual for calculation of group units of service.

LINE 11 INDIVIDUAL FACE TO FACE VISITS – **Enter** one (1) unit for each individual counseling session regardless of the length of time of the session. This information must be documented by the provider. To Line "H2", Form 7895B.

LINE 12 AVERAGE MINUTES IN AN INDIVIDUAL FACE TO FACE SESSION – **Computed by formula.** Total individual hours (LINE 18) divided by the total individual face to face visits (LINE 11) multiplied by 60 (minutes).

LINE 13 AVERAGE MINUTES IN A GROUP FACE TO FACE SESSION – **Computed by formula.** Total group hours (COLUMN D, LINE 15) divided by the total group sessions per year (COLUMN D, LINE 8) multiplied by 60 (minutes).

LINE 14 PERCENT OF GROUP FACE TO FACE VISITS – **Computed by formula.** Percentage of each cost center's group units (LINE 10) to the total group units of service (COLUMN D, LINE 10). These percentages will be used in the computation of group staff hours for each cost center.

LINE 15 GROUP HOURS – **Enter** the cumulative hours recorded for all group sessions for the year in **COLUMN D, LINE 15.** The group hours for **Private, Medi-Cal, and NNA** will be computed by the formula:

Total group hours (COLUMN D, LINE 15) multiplied by the percent of group face to face visits (LINE 14).

LINE 16 PERCENT OF TOTAL HOURS WITHIN COST CENTER – **Computed by formula.** Within each cost center, group hours (LINE 15) divided by total staff hours (LINE 20). This percentage will be used to compute the cost of group sessions.

LINE 17 PERCENT OF INDIVIDUAL UNITS OF SERVICE – **Computed by formula.** Percentage of each cost center's individual face to face units (LINE 11) to the total individual face to face units of service (COLUMN D, LINE 11).

LINE 18 INDIVIDUAL HOURS – **Enter** the cumulative hours recorded for all individual sessions for each cost center.

LINE 19 PERCENT OF TOTAL HOURS WITHIN COST CENTER – **Computed by formula.** Within each cost center, individual hours (LINE 18) divided by total staff hours (LINE 20). This percentage will be used to compute the cost of individual counseling sessions (units).

LINE 20 TOTAL STAFF HOURS – **Computed by formula.** Group hours (LINE 15) plus individual hours (LINE 18). To Line "I", Form 7895ODFAVG or 7895PODFAVG.

LINE 21 PERCENT OF TOTAL STAFF HOURS – **Computed by formula.** Percentage of each cost center's staff hours (LINE 20) to the total staff hours (COLUMN D, LINE 20). These percentages will be used to distribute costs to each cost center.

LINE 22 TOTAL MEDI-CAL UNREIMBURSABLE COSTS – **Computed by formula.** From PAGE 1, LINE 2s.

LINE 23 TOTAL DIRECT COSTS – **Computed by formula.** From PAGE 1, LINE 3s.

LINE 24 TOTAL DISTRIBUTED ADJUSTED GROSS COSTS – **Computed by formula.** Adjusted gross costs to be distributed (COLUMN D, LINE 5) times the percent of total staff hours (LINE 21).

LINE 25 TOTAL PROGRAM COSTS – **Computed by formula.** Adds total Medi-Cal unreimbursable costs (LINE 22), total direct costs (LINE 23), and total distributed adjusted gross costs (LINE 24) for each cost center.

LINE 26 TOTAL COSTS FOR DISTRIBUTION – **Computed by formula.**

For **Private and NNA**, the amount is from total program costs (LINE 25).

For **Medi-Cal**, adds total direct costs (LINE 23) and total distributed adjusted gross costs (LINE 24).

LINE 27 DISTRIBUTED GROUP COSTS – **Computed by formula.** Total costs for distribution (LINE 26) times percent of total (group) hours within a cost center (LINE 16).

LINE 28 TOTAL GROUP COUNTY ADMINISTRATION COSTS – **Computed by formula.** County Medi-Cal administration costs (LINE 6) multiplied by the percent of total (group) hours within cost center (LINE 16). To Line "A2", Form 7895ODFAVG or 7895PODFAVG.

LINE 29 GROUP TREATMENT COSTS – **Computed by formula.** Adds distributed group costs (LINE 27) and total group county administration costs (LINE 28). To Line "A1", Form 7895B.

LINE 30 COST PER GROUP SESSION – **Computed by formula.** Group treatment costs (LINE 29) divided by the number of group sessions by cost center (LINE 9).

LINE 31 COST PER GROUP FACE TO FACE VISIT – Group treatment costs (LINE 29) divided by total group face to face visits (LINE 10).

LINE 32 GROUP DRUG/MEDI-CAL MAXIMUM RATE – **Computed by formula.** The maximum rate is computed based on the **average minutes in a group face to face session.** If the average minutes in a group face to face session (LINE 13) is **equal to or greater than 90 (minutes),** the maximum rate will be reduced proportionally by multiplying the CAP by the average minutes in a group session (LINE 13) divided by 90 (minutes).

(For example, the average minutes of all Medi-Cal group session is **81** minutes, the rate cap of $32.50 [PN $45.73] would be reduced to **$29.25** [PN $41.16] [$32.50 {PN $45.73} times 81 divided by 90).

LINE 33 MAXIMUM ALLOWABLE MEDI-CAL COSTS FOR GROUP SESSION – **Computed by formula.** The **lower** of the cost per group session (LINE 30) or the group Drug/Medi-Cal maximum rate (LINE 32) times the number of group sessions by cost center (LINE 9).

LINE 34 ADJUSTED COST PER GROUP FACE TO FACE VISIT (**PROVISIONAL RATE**) – **Computed by formula.** The maximum allowable Medi-Cal costs for group sessions (LINE 33) divided by the total group face to face visits (LINE 10).

LINE 35 COSTS MOVED TO UNRESTRICTED FUNDING SOURCES – **Computed by formula.** The group treatment costs (LINE 29) less the maximum allowable Medi-Cal costs for group sessions (LINE 33).

LINE 36 DISTRIBUTED INDIVIDUAL COSTS – **Computed by formula.** Total costs for distribution (LINE 26) times percent of total (individual hours within a cost center (LINE 19).

LINE 37 TOTAL INDIVIDUAL COUNTY ADMINISTRATION – **Computed by formula.** County Medi-Cal administration costs (LINE 6) multiplied by the percent of total (individual) hours within cost center (LINE 19). To Line "B2", Form 7895B.

LINE 38 INDIVIDUAL TREATMENT COSTS – **Computed by formula.** Adds distributed individual costs (LINE 36) and total individual county administration costs (LINE 37). To Line "B1", Form 7895B.

LINE 39 COST PER INDIVIDUAL SESSION (FACE TO FACE VISIT) – **Computed by formula.** Individual treatment costs (LINE 38) divided by total individual face to face visits (LINE 11).

LINE 40 INDIVIDUAL DRUG/MEDI-CAL MAXIMUM RATE – **Computed by formula.** The maximum rate is computed based on the **average minutes in an individual face to face session.** If the average minutes in an individual face to face session (LINE 12) is **equal to or greater than 50 (minutes)**, the maximum rate will be $61.73 (PN $86.85). If the average minutes in an individual face to face session is **less than 50 (minutes)**, the maximum rate will be reduced proportionally by multiplying the CAP by the average minutes in an individual session (LINE 12) divided by 50 (minutes).

(For example, the average minutes of all Medi-Cal individual sessions is **45** minutes, the rate cap of $61.73 [PN $86.85] would be reduced to $55.56 [PN $78.16] [$61.73 {86.85} times 45 divided by 50]).

LINE 41 MAXIMUM ALLOWABLE MEDI-CAL COSTS FOR INDIVIDUAL SESSIONS – **Computed by formula.** The **lower** of the cost per individual session (LINE 39) or the individual Drug/Medi-Cal maximum rate (LINE 40) times the number of individual face to face visits (LINE 11).

LINE 42 ADJUSTED COST PER INDIVIDUAL SESSION (**PROVISIONAL RATE**) – **Computed by formula.** The maximum allowable Medi-Cal costs for individual sessions (LINE 41) divided by the total individual face to face visits (LINE 11).

LINE 43 COST MOVED TO UNRESTRICTED FUNDS – **Computed by formula.** The individual treatment costs (LINE 38) less the maximum allowable Medi-Cal costs for individual sessions (LINE 41).

LINE 44 TOTAL REIMBURSABLE COSTS – **Computed by formula.**

For **Unrestricted funds,** adds group costs moved to unrestricted funding sources (LINE 35) and individual costs moved to unrestricted funding sources (LINE 43). Should equal Column "C", Line "G1", Form 7895B.

For **Private and NNA,** adds group treatment costs (LINE 29) and individual treatment costs (LINE 38).

For **Medi-Cal,** add the maximum allowable Medi-Cal costs for group sessions (LINE 33) and maximum allowable Medi-Cal costs for individual sessions (LINE 41).

LINE 45 COST PER GROUP STAFF HOUR – **Computed by formula.**

For **Unrestricted,** group costs moved to unrestricted funding sources (LINE 35) divided by Medi-Cal group hours (COLUMN B, LINE 15).

For **Private and NNA**, group treatment costs (LINE 29) divided by group hours (LINE 15).

For **Medi-Cal,** maximum allowable Medi-Cal costs for group sessions (LINE 33) divided by group hours (LINE 15).

LINE 46 COST PER INDIVIDUAL STAFF HOUR – **Computed by formula.**

For **Unrestricted**, individual costs moved to unrestricted funding sources (LINE 43) divided by Medi-Cal individual hours (COLUMN B, LINE 18).

For **Private and NNA**, individual treatment costs (LINE 38) divided by individual hours (LINE 18).

For **Medi-Cal**, maximum allowable Medi-Cal costs for individual sessions (LINE 41) divided by individual hours (LINE 18).

LINE 47 COST PER TOTAL STAFF HOUR – **Computed by formula.**

For **Unrestricted,** total reimbursable costs (LINE 44) divided by total staff hours for Medi-Cal (COLUMN B, LINE 20).

For **Private, Medi-Cal, and NNA,** total reimbursable costs (LINE 44) divided by total staff hours (LINE 20).

LINE 48 TOTAL MEDI-CAL COSTS (GROUP + INDIVIDUAL TREATMENT) – **Computed by formula.** Group treatment costs (LINE 29) added to individual treatment costs (LINE 38). This is the total costs allocated to Medi-Cal and can be verified by adding total unrestricted reimbursable costs (LINE 44) to total Medi-Cal reimbursable costs (COLUMN B, LINE 44).

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INSTRUCTIONS FOR ODF AVERAGE WORKSHEET (ODFAVG) and PERINATAL AVERAGE WORKSHEET (PODFAVG)

The ODF **Average** Worksheet (ODFAVG) may be used to develop the ODF budget and cost report. There are separate worksheets for D/MC and Perinatal Medi-Cal. Entries are only required on page 1 in the blank cells highlighted in yellow (shaded on hard copy). All other cells contain formulas. **Please do not change any of the formulas.**

Providers will maintain the following documentation:

1. Group Sessions
   (a) Group rosters by client name showing the payor for each client.
   (b) Date, start time, and end time of the session.
   (c) Counselor's name.

2. Individual Sessions
   (a) Counselor's calendar, schedule, etc. which indicates the name of the client, date, start time, and end time of every individual counseling session.

3. All documentation must be traceable to client records.

The following are Form ODFAVG instructions:

Page 1

LINE 1 TOTAL GROSS COSTS – **Enter** the **total costs** to operate the program in Column D. These costs must be traceable to the provider's accounting records.

LINE 2 ADJUSTMENTS FOR MEDI-CAL UNREIMBURSABLE COSTS – **Enter** the costs of **services, that are program requirements**, but are not allowable within the Utilization Control Plan in Column A and Column C. The Medi-Cal share of such costs must be identified and entered as a cost chargeable to the NNA and/or Private cost center.

(For example: Some Perinatal required services, such as child care (baby sitting), is a Perinatal requirement that is not Medi-Cal reimbursable. Also, certain SAPT Block Grant requirements for HIV and TB would not be Medi-Cal reimbursable.)

LINE 3 ADJUSTMENTS FOR DIRECT COSTS – **Enter** the costs of **services** that are applicable to a single cost center.

(For example: URC Costs are a direct cost only to the Medi-Cal cost center. The amount of such costs would be indicated in the Medi-Cal cost center).

LINE 4 TOTAL ADJUSTMENTS FOR MEDI-CAL UNREIMBURSABLE AND DIRECT COSTS – **Computed by formula.** Total of all Medi-Cal unreimbursable and direct costs entered in Lines 1 and 2.

LINE 5 ADJUSTED GROSS COSTS TO BE DISTRIBUTED – **Computed by formula.** Total gross costs (LINE 1) minus total Medi-Cal unreimbursable and direct costs (LINE 4). These costs represent equal services to all clients.

LINE 6 COUNTY MEDI-CAL ADMINISTRATION – **Enter** the amount of county administration (**URC, billing, and training**) incurred by the county. These costs must be supported by the county's accounting records.

LINE 7 TOTAL COSTS (PROGRAM AND COUNTY MEDI-CAL ADMINISTRATION) – **Computed by formula.** Adds total adjustments for Medi-Cal unreimbursable and direct costs (LINE 4), adjusted gross costs to be distributed (LINE 5), and county Medi-Cal administration (LINE 6).

LINE 8 TOTAL GROUP SESSIONS FOR THE YEAR – **Enter** the number of group sessions held by the provider. This information must be documented by the provider. To Column "A", Line "N", Form 7895ODFAVG or 7895PODFAVG.

(For example, if a provider holds 2 group sessions a day, 5 days a week, 52 weeks a year – this number will be 520).

LINE 9 NUMBER OF GROUP SESSIONS BY COST CENTER – For each cost center, **enter** the number of sessions in which at least one (1) of the cost center's clients participated. This information must be documented by the provider. To Columns B, C, and D, Line "N", Form 7895ODFAVG or 7895PODFAVG.

(For example, of the 520 total groups sessions (LINE 8 example), review of the group rosters indicated private clients participated in 120 groups, Medi-Cal clients in 490 groups, and NNA clients in 410 groups – enter 120 (Private), 490 (Medi-Cal), and 410 (NNA).

NOTE: Since most group sessions contain participants from all cost centers, the number of group sessions will not add up to the total on Line 8.

LINE 10 TOTAL GROUP FACE TO FACE VISITS (GROUP UNITS OF SERVICE) – **Enter** the actual number of clients who participated in each of the group sessions. This information must be documented by the provider. No comparable line in 7895ODF/7895OPN. These forms require detailed entries by funding source.

See Page 14 of the Drug Program Fiscal Systems Manual for calculation of group units of service.

LINE 11 INDIVIDUAL FACE TO FACE VISITS – **Enter** one (1) unit for each individual counseling session regardless of the length of time of the session. This information must be documented by the provider. No comparable line in 7895ODF/7895OPN. These forms require detailed entries by funding source.

LINE 12 AVERAGE MINUTES IN AN INDIVIDUAL FACE TO FACE SESSION – **Enter** the average length of time **in minutes** of all individual face to face sessions for the year.

For example, a provider held 1,000 individual face to face sessions of various time lengths for a total of 47,200 minutes. The average minutes would be 47.20 (47,200 divided by 1000).

LINE 13 AVERAGE MINUTES IN A GROUP FACE TO FACE SESSION – **Enter** the average length of time in **minutes** of all group face to face sessions for the year. Keep in mind that school-based programs of shorter duration will reduce the average.

For example, a provider held 1,000 group sessions of various time lengths for a total of 75,000 minutes. The average minutes would be 75.00 (75,000 divided by 1000).

LINE 14 PERCENT OF GROUP FACE TO FACE VISITS – **Computed by formula.** Percentage of each cost center's group units (LINE 10) to the total group units of service (COLUMN D, LINE 10). These percentages will be used in the computation of group staff hours for each cost center.

LINE 15 GROUP HOURS – **Computed by formula.** The total group sessions for the year (COLUMN D, LINE 8) multiplied by the average minutes in a group face to face session (LINE 13) times the percent of group face to face visits (LINE 14).

LINE 16 PERCENT OF TOTAL HOURS WITHIN COST CENTER – **Computed by formula.** Within each cost center, group hours (LINE 15) divided by total staff hours (LINE 20). This percentage will be used to compute the cost of group sessions.

LINE 17 PERCENT OF INDIVIDUAL UNITS OF SERVICE – **Computed by formula.** Percentage of each cost center's individual face to face units (LINE 11) to the total individual face to face units of service (COLUMN D, LINE 11).

LINE 18 INDIVIDUAL HOURS – **Computed by formula.** The individual face to face visits (LINE 11) multiplied by the average minutes in an individual face to face session (LINE 12) divided by 60 (minutes).

LINE 19 PERCENT OF TOTAL HOURS WITHIN COST CENTER – **Computed by formula.** Within each cost center, individual hours (LINE 18) divided by total staff hours (LINE 20). This percentage will be used to compute the cost of individual counseling sessions (units).

LINE 20 TOTAL STAFF HOURS – **Computed by formula.** Group hours (LINE 15) plus individual hours (LINE 18). To Line "M", Form 7895ODFAVG or 7895PODFAVG.

LINE 21 PERCENT OF TOTAL STAFF HOURS – **Computed by formula.** Percentage of each cost center's staff hours (LINE 20) to the total staff hours (COLUMN D, LINE 20). These percentages will be used to distribute costs to each cost center.

LINE 22 TOTAL MEDI-CAL UNREIMBURSABLE COSTS – **Computed by formula.** From PAGE 1, LINE 2s.

LINE 23 TOTAL DIRECT COSTS – **Computed by formula.** From PAGE 1, LINE 3s.

LINE 24 TOTAL DISTRIBUTED ADJUSTED GROSS COSTS – **Computed by formula.** Adjusted gross costs to be distributed (COLUMN D, LINE 5) times the percent of total staff hours (LINE 21).

LINE 25 TOTAL PROGRAM COSTS – **Computed by formula.** Adds total Medi-Cal unreimbursable costs (LINE 22), total direct costs (LINE 23), and total distributed adjusted gross costs (LINE 24) for each cost center.

LINE 26 TOTAL COSTS FOR DISTRIBUTION – **Computed by formula.**

For **Private and NNA**, the amount is from total program costs (LINE 25).

For **Medi-Cal**, adds total direct costs (LINE 23) and total distributed adjusted gross costs (LINE 24).

LINE 27 DISTRIBUTED GROUP COSTS – **Computed by formula.** Total costs for distribution (LINE 26) times percent of total (group) hours within a cost center (LINE 16).

LINE 28 TOTAL GROUP COUNTY ADMINISTRATION COSTS – **Computed by formula.** County Medi-Cal administration costs (LINE 6) multiplied by the percent of total (group) hours within cost center (LINE 16). To Line "G1", Form 7895ODFAVG or 7895PODFAVG.

LINE 29 GROUP TREATMENT COSTS – **Computed by formula.** Adds distributed group costs (LINE 27) and total group county administration costs (LINE 28).

LINE 30 COST PER GROUP SESSION – **Computed by formula.** Group treatment costs (LINE 29) divided by the number of group sessions by cost center (LINE 9).

LINE 31 COST PER GROUP FACE TO FACE VISIT – Group treatment costs (LINE 29) divided by total group face to face visits (LINE 10).

LINE 32 GROUP DRUG/MEDI-CAL MAXIMUM RATE PER GROUP FACE TO FACE VISIT – **Computed by formula.** The maximum rate is computed based on the **average minutes in a group face to face session.** If the average minutes in a group face to face session (LINE 13) is **equal to or greater than 90 (minutes),** the maximum rate PER GROUP FACE TO FACE VISIT WILL BE $32.50 (pn $45.73). If the average minutes in a group face to face session is **less than 90 (minutes),** the maximum rate will be reduced proportionally by multiplying the CAP by the average minutes in a group session (LINE 13) divided by 90 (minutes).

(For example, the average minutes of all Medi-Cal group session is **81** minutes, the rate cap of $32.50 [PN $45.73] would be reduced to **$29.25** [PN $41.16] [$32.50 {PN $45.73} times 81 divided by 90).

LINE 33 MAXIMUM ALLOWABLE MEDI-CAL COSTS FOR GROUP FACE TO FACE VISITS – **Computed by formula.** The **lower** of the cost per group face to face visit (LINE 32) or the Drug/Medi-Cal maximum rate per face to face visit (LINE 32) times the number of group face to face visits by cost center (LINE 10).

LINE 34 ADJUSTED COST PER GROUP FACE TO FACE VISIT (**PROVISIONAL RATE**) – **Computed by formula.** The maximum allowable Medi-Cal costs for group sessions (LINE 33) divided by the total group face to face visits (LINE 10).

LINE 35 COSTS MOVED TO UNRESTRICTED FUNDING SOURCES – **Computed by formula.** The group treatment costs (LINE 29) less the maximum allowable Medi-Cal costs for group sessions (LINE 33).

LINE 36 DISTRIBUTED INDIVIDUAL COSTS – **Computed by formula.** Total costs for distribution (LINE 26) times percent of total (individual) hours within a cost center (LINE 19).

LINE 37 TOTAL INDIVIDUAL COUNTY ADMINISTRATION – **Computed by formula.** County Medi-Cal administration costs (LINE 6) multiplied by the percent of total (individual) hours within cost center (LINE 19).

LINE 38 INDIVIDUAL TREATMENT COSTS – **Computed by formula.** Adds distributed individual costs (LINE 36) and total individual county administration costs (LINE 37).

LINE 39 COST PER INDIVIDUAL SESSION (FACE TO FACE VISIT) – **Computed by formula.** Individual treatment costs (LINE 38) divided by total individual face to face visits (LINE 11).

LINE 40 INDIVIDUAL DRUG/MEDI-CAL MAXIMUM RATE – **Computed by formula.** The maximum rate is computed based on the **average minutes in an individual face to face session.** If the average minutes in an individual face to face session (LINE 12) is **equal to or greater than 50 (minutes)**, the maximum rate will be $61.73 (PN $86.85). If the average minutes in an individual face to face session is **less than 50 (minutes)**, the maximum rate will be reduced proportionally by multiplying the CAP by the average minutes in an individual session (LINE 12) divided by 50 (minutes).

(For example, the average minutes of all Medi-Cal individual sessions is **45** minutes, the rate cap of $61.73 [PN $86.85] would be reduced to $55.56 [PN $78.16] [$61.73 {86.85} times 45 divided by 50]).

LINE 41 MAXIMUM ALLOWABLE MEDI-CAL COSTS FOR INDIVIDUAL SESSIONS – **Computed by formula.** The **lower** of the cost per individual session (LINE 39) or the individual Drug/Medi-Cal maximum rate (LINE 40) times the number of individual face to face visits (LINE 11).

LINE 42 ADJUSTED COST PER INDIVIDUAL SESSION (**PROVISIONAL RATE**) – **Computed by formula.** The maximum allowable Medi-Cal costs for individual sessions (LINE 41) divided by the total individual face to face visits (LINE 11).

LINE 43 COST MOVED TO UNRESTRICTED FUNDS – **Computed by formula.** The individual treatment costs (LINE 38) less the maximum allowable Medi-Cal costs for individual sessions (LINE 41).

LINE 44 TOTAL REIMBURSABLE COSTS – **Computed by formula.**

For **Unrestricted funds,** adds group costs moved to unrestricted funding sources (LINE 35) and individual costs moved to unrestricted funding sources (LINE 43).

For **Private and NNA,** adds group treatment costs (LINE 29) and individual treatment costs (LINE 38).

For **Medi-Cal,** add the maximum allowable Medi-Cal costs for group sessions (LINE 33) and maximum allowable Medi-Cal costs for individual sessions (LINE 41).

LINE 45 COST PER GROUP STAFF HOUR – **Computed by formula.**

For **Unrestricted,** group costs moved to unrestricted funding sources (LINE 35) divided by Medi-Cal group hours (COLUMN B, LINE 15).

For **Private and NNA**, group treatment costs (LINE 29) divided by group hours (LINE 15).

For **Medi-Cal,** maximum allowable Medi-Cal costs for group sessions (LINE 33) divided by group hours (LINE 15).

LINE 46 COST PER INDIVIDUAL STAFF HOUR – **Computed by formula.**

For **Unrestricted**, individual costs moved to unrestricted funding sources (LINE 43) divided by Medi-Cal individual hours (COLUMN B, LINE 18).

For **Private and NNA**, individual treatment costs (LINE 38) divided by individual hours (LINE 18).

For **Medi-Cal**, maximum allowable Medi-Cal costs for individual sessions (LINE 41) divided by individual hours (LINE 18).

LINE 47 COST PER TOTAL STAFF HOUR – **Computed by formula.**

For **Unrestricted,** total reimbursable costs (LINE 44) divided by total staff hours for Medi-Cal (COLUMN B, LINE 20).

For **Private, Medi-Cal, and NNA,** total reimbursable costs (LINE 44) divided by total staff hours (LINE 20).

LINE 48 TOTAL MEDI-CAL COSTS (GROUP + INDIVIDUAL TREATMENT) – **Computed by formula.** Group treatment costs (LINE 29) added to individual treatment costs (LINE 38). This is the total costs allocated to Medi-Cal and can be verified by adding total unrestricted reimbursable costs (LINE 44) to total Medi-Cal reimbursable costs (COLUMN B, LINE 44).

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DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS
DRUG MEDI-CAL FISCAL DETAIL

DRUG MEDI-CAL PROGRAM COST SUMMARY
County Contract Submission

FISCAL YEAR 1998-99

COUNTY: _____
PROVIDER: _____ MEDI-CAL PROVIDER #: _____
CONTRACT PERIOD: _____ CADDS PROVIDER #: _____
DATE PREPARED: _____

UNIT OF SERVICE RATE	Provider Rate	Admin. Rate	Total Daily Rate
Daily Dose - Methadone	6.61	0.67	7.28
Daily Dose - LAAM	14.91	1.50	16.41
Individual Counseling @ 10 min.	11.22	1.13	12.35
Group Counseling @ 10 min.	3.28	0.33	3.61

					Time Period Split Out			
					Regular	Regular	Minor Consent	
NUMBER OF UNITS OF SERVICE	Submitted UOS	Denied UOS	Adjusted UOS	Final UOS	7/1/98 to 9/30/98	10/1/98 to 6/30/99	7/1/98 to 6/3/099	Check Total
Daily Dose - Methadone				0				0
Daily Dose - LAAM				0				0
Individual Counseling @ 10 min.				0				0
Group Counseling @ 10 min.				0				0

TOTAL REIMBURSEMENT	Provider Reimb.	Admin. Reimb.	Total Reimb.
Daily Dose - Methadone	0.00	0.00	0.00
Daily Dose - LAAM	0.00	0.00	0.00
Individual Counseling @ 10 min.	0.00	0.00	0.00
Group Counseling @ 10 min.	0.00	0.00	0.00
TOTAL	0.00	0.00	0.00

Total Methadone Milligrams	
Total LAAM Milligrams	

FINAL UOS REIMBURSEMENT	Final UOS	Federal Share	State Share	Final Reimb.	Share of Costs	Net Reimb.
- July thru September		51.23%	48.77%			
Daily Dose - Methadone	0	0.00	0.00	0.00		
Daily Dose - LAAM	0	0.00	0.00	0.00		
Individual Counseling @ 10 min.	0	0.00	0.00	0.00		
Group Counseling @ 10 min.	0	0.00	0.00	0.00		
- October thru June		51.55%	48.45%			
Daily Dose - Methadone	0	0.00	0.00	0.00		
Daily Dose - LAAM	0	0.00	0.00	0.00		
Individual Counseling @ 10 min.	0	0.00	0.00	0.00		
Group Counseling @ 10 min.	0	0.00	0.00	0.00		
- July thru June (Minor Consent)		0.00%	100.00%			
Daily Dose - Methadone	0	0.00	0.00	0.00		
Daily Dose - LAAM	0	0.00	0.00	0.00		
Individual Counseling @ 10 min.	0	0.00	0.00	0.00		
Group Counseling @ 10 min.	0	0.00	0.00	0.00		
GRAND TOTAL		0.00	0.00	0.00		0

Form: ADP 7990NAC.XLS (7/99)

COMPLETION INSTRUCTIONS
DRUG MEDI-CAL FISCAL DETAIL
NARCOTIC TREATMENT PROGRAM
DRUG MEDI-CAL PROGRAM COST SUMMARY
County Contract Submission
Alcohol and Drug Services (Non-Perinatal)
FISCAL YEAR 1998-99

(Note: Limit the claim information on this form to the fiscal year indicated in the heading and treatment element identified. Do not include claim information from previous fiscal years.)

NOTE: The "FY 1998-99 Cost Report Forms" diskette contains the files which include the formulas for this form. The Excel file name for this form is 7990NAC.XLS. Do not enter information in the cells where a "0" is located. These areas will automatically be calculated.

HEADING INSTRUCTIONS

Enter: County Name, Provider Name, Contract Period, Date Prepared, Medi-Cal Provider Number (billing number), and CADDS Provider Number.

SECTION INSTRUCTIONS – UNIT OF SERVICE RATE

Changes in this area are only allowed if the provider claims at a customary charge which is less than the DMC Maximum rate. If that is the case, enter the customary charge rate under the "Provider Rate" column for the affected service areas. **DO NOT CHANGE THE ADMINISTRATIVE RATE.**

SECTION INSTRUCTIONS – NUMBER OF UNITS OF SERVICE

1. Enter the total units of service submitted for the fiscal year in the Submitted UOS column for each service provided.

2. Enter the total number of denied units of service for the fiscal year in the Denied UOS column for each service provided.

3. Enter the total number of adjusted units of service (obtained from ADP 5035C – Provider Report of DMC Claims Adjustment) for the fiscal year in the Adjusted UOS column for each service provided. The Final UOS column contains a formula to calculate the correct entry.

4. Enter the total units of service for the time period between July 1, 1998 and September 30, 1998 in the Regular 7/1/98 to 9/30/98 column for each service provided.

5. Enter the total units of service for the time period between October 1, 1998 and June 30, 1999 in the Regular 10/1/98 to 6/30/99 column for each service provided.

6. Enter the total number of Minor Consent units of service for the entire fiscal year in the Minor Consent 7/1/98 to 6/30/99 column for each service provided.

7. The Check Total column contains a formula to calculate the total units of service for the entire fiscal year. The figures in the Final UOS Column and the Check Total column must be the same, if not the figures should be adjusted to equal the same amount for each service provided.

SECTION INSTRUCTIONS – TOTAL MILLIGRAMS

1. Enter the total number of Methadone Milligrams dispensed during the fiscal year.

2. Enter the total number of LAAM Milligrams dispensed during the fiscal year.

SECTION INSTRUCTIONS – FINAL UOS REIMBURSEMENT

1. Enter the total share of costs collected for the entire fiscal year in the Share of Cost column in the Grand Total line.

All other entries within the Narcotic Treatment Program, Drug Media-Cal Program Cost Summary form (ADP 7990NAC) will be calculated according to the units of service information provided and reimbursement will be calculated accordingly.

DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS
DRUG MEDI-CAL FISCAL DETAIL
NARCOTIC TREATMENT PROGRAM
DRUG MEDI-CAL PROGRAM COST SUMMARY
County Contract Submission
Perinatal Services
FISCAL YEAR 1998-99

COUNTY: _____
PROVIDER: _____ MEDI-CAL PROVIDER #: _____
CONTRACT PERIOD: _____ CADDS PROVIDER #: _____
DATE PREPARED: _____

UNIT OF SERVICE RATE	Provider Rate	Admin. Rate	Total Daily Rate
Daily Dose - Methadone	7.49	0.75	8.24
Individual Counseling @ 10 min.	15.78	1.59	17.37
Group Counseling @ 10 min.	4.62	0.46	5.08

					Time Period Split Out		
NUMBER OF UNITS OF SERVICE	Submitted UOS	Denied UOS	Adjusted UOS	Final UOS	7/1/98 to 9/30/98	10/1/98 to 6/30/99	Check Total
Daily Dose - Methadone				0			0
Individual Counseling @ 10 min.				0			0
Group Counseling @ 10 min.				0			0

TOTAL REIMBURSEMENT	Provider Reimb.	Admin. Reimb.	Total Reimb.
Daily Dose - Methadone	0.00	0.00	0.00
Individual Counseling @ 10 min.	0.00	0.00	0.00
Group Counseling @ 10 min.	0.00	0.00	0.00
TOTAL	0.00	0.00	0.00

Total Methadone Milligrams	

FINAL UOS REIMBURSEMENT	Final UOS	Federal Share	State Share	Final Reimb.	Share of Costs	Net Reimb.
- July thru September		51.23%	48.77%			
Daily Dose - Methadone	0	0.00	0.00	0.00		
Individual Counseling @ 10 min.	0	0.00	0.00	0.00		
Group Counseling @ 10 min.	0	0.00	0.00	0.00		
- October thru June		51.55%	48.45%			
Daily Dose - Methadone	0	0.00	0.00	0.00		
Individual Counseling @ 10 min.	0	0.00	0.00	0.00		
Group Counseling @ 10 min.	0	0.00	0.00	0.00		
GRAND TOTAL		0.00	0.00	0.00		0

Form: ADP 7990NPC (7/99)

COMPLETION INSTRUCTIONS
DRUG MEDI-CAL FISCAL DETAIL
NARCOTIC TREATMENT PROGRAM
DRUG MEDI-CAL PROGRAM COST SUMMARY
County Contract Submission
Perinatal Services
FISCAL YEAR 1998-99

(Note: Limit the claim information on this form to the fiscal year indicated in the heading and treatment element identified. Do not include claim information from previous fiscal years.)

NOTE: The "FY 1998-99 Cost Report Forms" diskette contains the files which include the formulas for this form. The Excel file name for this form is 7990NPC.XLS. Do not enter information in the cells where a "0" is located. These areas will automatically be calculated.

HEADING INSTRUCTIONS

Enter: County Name, Provider Name, Contract Period, Date Prepared, Medi-Cal Provider Number (billing number), and CADDS Provider Number.

SECTION INSTRUCTIONS – UNIT OF SERVICE RATE

Changes in this area are only allowed if the provider claims at a customary charge which is less than the DMC Maximum rate. If that is the case, enter the customary charge rate under the "Provider Rate" column for the affected service areas. **DO NOT CHANGE THE ADMINISTRATIVE RATE.**

SECTION INSTRUCTIONS – NUMBER OF UNITS OF SERVICE

1. Enter the total units of service submitted for the fiscal year in the Submitted UOS column for each service provided.

2. Enter the total number of denied units of service for the fiscal year in the Denied UOS column for each service provided.

3. Enter the total number of adjusted units of service (obtained from ADP 5035C – Provider Report of DMC Claims Adjustments) for the fiscal year in the Adjusted UOS column for each service provided. The Final UOS column contains a formula to calculate the correct entry.

4. Enter the total units of service for the time period between July 1, 1998 and September 30, 1998 in the Regular 7/1/98 to 9/30/98 column for each service provided.

5. Enter the total units of service for the time period between October 1, 1998 and June 30, 1999 in the Regular 10/1/98 to 6/30/99 column for each service provided.

6. The Check Total column contains a formula to calculate the total units of service for the entire fiscal year. The figures in the Final UOS Column and the Check Total column must be the same, if not the figures should be adjusted to equal the same amount for each service provided.

SECTION INSTRUCTIONS – TOTAL MILLIGRAMS

1. Enter the total number of Methadone Milligrams dispensed during the fiscal year.

SECTION INSTRUCTIONS – FINAL UOS REIMBURSEMENT

1. Enter the total share of costs collected for the entire fiscal year in the Share of Cost column in the Grand Total line.

All other entries within the Narcotic Treatment Program, Drug Medi-Cal Program Cost Summary form (ADP 7990NPC) will be calculated according to the units of service information provided and reimbursement will be calculated accordingly.

SUBMISSION OF COST REPORT DOCUMENTS

COUNTIES

FY 1998-99

The following must be submitted as the FY 1998-99 Cost Report.

- The County Certification form (ADP I7885)
- Paradox Diskette
- Print of all Reports: Year-End Claim for Reimbursement, Fiscal Detail Report by Modality; Prevention/Treatment Summary Report, County Allocation Report, and Error Message Report.

If there are DMC providers within the county, the specific DMC forms to be submitted based on the type of modality are listed below:

- Day Care Habilitative (DCH)

  1. ADP 7990
  2. ADP 7895
  3. DCHFUND (if both NNA and DMC funding)

- Perinatal Residential (RES)

  1. ADP 7990
  2. ADP 7895

- Outpatient Drug Free (ODF) – Individual Counseling

  1. ADP 7990
  2. ADP 7895
  3. ODFIFUND (if both NNA and DMC funding)

- Outpatient Drug Free (ODF) – Group Counseling

  1. ADP 7990
  2. ADP 7895
  3. ODFGFUND (if both NNA and DMC funding)

- Naltrexone (NAL)

  1. ADP 7990
  2. ADP 7895M

- Narcotic Treatment Program (NTP) – With ONLY NTP DMC Funding

  1. ADP 7990NAC and/or ADP7990NPC

- Narcotic Treatment Program (NTP) – With Funding Sources in Addition to NTP DMC Funding

  1. ADP 7990NAC and/or ADP7990NPC
  2. ADP 7895M

FINAL DRUG MEDI-CAL RATES FOR FISCAL YEAR 1998-99

Program Code: 20 (Alcohol and Drug Services)

Description	Service Function Code	Unit of Service (UOS)	FY 1998-99 UOS Rate	Maximum Allowance
Narcotic Treatment Program (NTP) – Methadone	20, 21, and 22	Daily	$7.28 $.67*	Maximum
NTP Levo-Alpha Acetyl Methadol (LAAM)	23, 24, and 25	Dose	$16.41 $1.50*	Maximum
NTP - Individual Counseling (**)	26, 27	One 10-minute increment	$12.35 $1.13*	Maximum
NTP - Group Counseling (**)	28, 29	One 10-minute increment	$3.61 $.33*	Maximum
Day Care Habilitative (DCH)	30 through 39	Face-to-Face Visit	$65.95	Maximum
Perinatal Residential (RES)	Not Applicable			
Naltrexone (NAL)	50 through 59	Face-to-Face Visit	$35.69	Maximum
Outpatient Drug Free (ODF) – Individual Counseling	80 through 84	Face-to-Face Visit (Per Person)	$61.73	Maximum
ODF - Group Counseling	85 through 89	Face-to-Face Visit (Per Person)	$32.50	Maximum

Program Code: 25 (Perinatal Services)

Description	Service Function Code	Unit of Service (UOS)	FY 1998-99 UOS Rate	Maximum Allowance
NTP – Methadone	20, 21, and 22	Daily	$8.24 $.75*	Maximum
NTP – LAAM	Not Applicable			
NTP - Individual Counseling (**)	26, 27	One 10-minute increment	$17.37 $1.59*	Maximum
NTP - Group Counseling (**)	28, 29	One 10-minute increment	$5.08 $.46*	Maximum
DCH	30 through 39	Face-to-Face Visit	$80.83	Maximum
RES	40 through 49	Daily	$80.61	Maximum
NAL	Not Applicable			
ODF - Individual Counseling	80 through 84	Face-to-Face Visit (Per Person)	$86.85	Maximum
ODF - Group Counseling	85 through 89	Face-to-Face Visit (Per Person)	$45.73	Maximum

The FY 1998-99 rates were submitted by the Office of Administrative Law to the Secretary of State for emergency filing and were effective as of July 1, 1998.

(*) Administrative Costs which are incorporated within the rate.

(**) ADP shall reimburse Narcotic Treatment Program (NTP) providers up to 200 minutes of counseling per calendar month, per beneficiary for Methadone and LAAM services only. Counseling shall be individual and/or group counseling.

G:\GROUPS3\FM\RATES\98-99\RATECHART.DOC (Updated June 30, 1998)

CHECKLIST

FY 1998-99 Cost Report

This checklist has been designed to assist you in the development of your cost report. By using the checklist you can assure that funding requirements have been met and that required computations are correct. Accuracy in the completion of the your cost report will expedite the interim settlement and significantly reduce the number of contacts between county and State staff in correcting omissions or inconsistencies.

The Worksheets are:

* Form 7885 - Year-End Claim for Reimbursement
* Form 7885A - Summary (Page 1 of 2)
* Form 7885B - Summary (Page 2 of 2)
* Form 7885C - Support Services
* Form 7885D - Primary Prevention Services
* Form 7885E - Secondary Prevention Services
* Form 7885F - Nonresidential Services
* Form 7885G - Residential Services
* Form 7885H - Chemically Assisted Treatment
* Form 7885I - Ancillary Services
* Form 7885K - DUI by Provider

Forms 7885A and 7885B

____ Form 7885A, column B, the sum of lines 50 through 56 (primary prevention 20% requirement) is equal to or more than the allocation requirement.

____ Form 7885B, column K, the sum of lines 40 through 80x minus line 58, 58a, 79, 80, and 80e, are within the final allocation amount.

____ Form 7885B, all required 10% county match for all State General Funds including DMC overages not used as Medi-Cal match for counties with population over 100,000 is included in lines 81c and 87c.

____ Form 7885B, column K, the sum of lines 94 and 96 equals the sum of column K, lines 45, 50 through 56 (federal block grant/substance abuse block grant).

____ Form 7885B, column K, lines 94 and 96, a minimum of 35% of the total block grant is expended on both alcohol and drug services.

____ The line totals on Form 7885B, column K equal the line total on Form 7885, column A.

____ Column totals on Forms 7885A & 7885B equal the totals on all of the supporting pages (Forms 7885C through 7885K, column F).

____ Forms 7885, 7885A & 7885B, line 83 equals excess fees collected and not expended in FY 1997-98.

____ Form 7885A, column A or Form 7885C, column F, Line 46, - no more than 10% of the total budgeted (continued funds from FY 1994-95 only) Parolee Services Network funds may be used in Support Services. **NOTE: No more than 5% (Administrative Cap which cannot be exceeded) of the total budgeted (new funds awarded in FY 1995-96 only) Parolee Services Network funds may be used in Support Services. Specific information for each of the Parolee Service Network participants is provided in the Funding Descriptions documents.**

____ Form 7885A, column A or Form 7885C, column F, Line 62 - no more than ***5%*** (Administrative Cap which cannot be exceeded) of the total budgeted SDFSC - School Based Prevention funds may be used in Support Services for administrative costs.

_____ Form 7885A, column A or Form 7885C, column F, Line 66 - no more than ***5%*** (Administrative Cap which cannot be exceeded) of the total budgeted SDFSC - Friday Night Live funds may be used in Support Services for administrative costs.

____ Form 7885A, column A or Form 7885C, column F, Line 68 - no more than ***5%*** (Administrative Cap which cannot be exceeded) of the total budgeted SDFSC - Club Live funds may be used in Support Services for administrative costs.

____ Form 7885A, column A or Form 7885C, column F, Line 86 - no more than ***5%*** (Administrative Cap which cannot be exceeded) of the total budgeted SB 920 and/or SB 921 funds may be used in Support Services for administrative costs.

____ Form 7885A, column A or Form 7885C, column F, Line 89 - no more than ***5%*** (Administrative Cap which cannot be exceeded) of the total budgeted DUI funds may be used in Support Services for administrative costs without a waiver from the Department.

____ If a county=s population exceeds 20,000, State General Funds are not allowed in DUI programs.

____ At least 33% of the total SB 920 and/or SB 921 funds must be used towards Primary Prevention.

____ No more than 5% of the total of Line 68a (CA Mentor Initiative) may be used in Support Services.

Forms 7885C through 7885K (Detail Pages)

____ The 6-digit provider code is listed for each provider on all required detail pages.

____ Each provider code is consistent with the ADP Master Provider File for the program and location.

____ The 1 or 2 digit program code is listed for each provider on all required detail pages.

____ The 2-digit service code is listed for each provider on all required detail pages.

____ Include the units of service and the cost per unit.

____ If applicable, include the ancillary units.

____ Form 7885K, line 89 contain only the funds collected and used for direct services. Fees for County administration are reflected on Form 7885E, line 89.

Form 7990

____ To verify separate accounting of alcohol/drug services or perinatal services: cross-check provider forms with Form 7885F (nonresidential services) and Form 7885H (residential services), and Form G (narcotic treatment for Naltrexone only) by provider. This form also accounts for the Reconciliation of Claims (formerly collected on ADP 7415).

Form 7990NAC or 7990NPC

____ To verify separate accounting of alcohol/drug services or perinatal service: cross check with provider forms with Form 7885G (narcotic treatment) by provider.

Forms 7895 or 7895M

____ Form 7895 - services are limited to ***ODF Group, ODF Individual, RES and DCH.***

____ Form 7895M - services are limited to ***NTP and NAL***.

Forms ODFGFUND, ODFIFUND, DCHFUND

____ **Form ODFGFUND** - If both NNA and D/MC funding is identified for a provider with ODF Group Counseling, this form must be completed (with all edits eliminated and all message 'OKAY'), signed by the county representative, and submitted with the cost report.

____ **Form ODFIGFUND** - If both NNA and D/MC funding is identified for a provider with ODF Individual Counseling, this form must be completed (with all edits eliminated and all message 'OKAY'), signed by the county representative, and submitted with the cost report.

____ **Form DCHFUND** - If both NNA and D/MC funding is identified for a provider with DCH services, this form must be completed (with all edits eliminated and all message 'OKAY'), signed by the county representative, and submitted with the cost report.

Filename: G:\GROUPS3\FM\COST8-9\89-checklist.doc (7/99)

Re. "Instructions on How to Read Your Remittance Advice (STD. 404)" is as the hard copy is in the ADP Bulletin. Please contact the Department of Alcohol and Drug Programs if you need the missing part of this computer file, the Remittance Advice (STD. 404) itself. Thank you.

INSTRUCTIONS ON
HOW TO READ YOUR REMITTANCE ADVICE (STD. 404)

When funds are scheduled for payment, a Remittance Advice (RA) (STD. 404) is mailed with the warrant. There should be no exceptions to this process as the RA contains the mailing address for the vendor.

The RA contains the identifying information such as the Department from which the warrant is generated, the vendor name and address, the schedule number, and any identifying information for the payment.

Field #1: Schedule No. This field represents the claim schedule number from which the payment was generated.

Field #2: Vendor. This is the mailing address for the vendor. This information is on file in the Accounting Office of the Department of Alcohol & Drug Programs. County payments are generally mailed to the County Treasurer's Office only. Direct contract vendors will have the address that has been submitted on the Vendor Data Form (Form 204) which should generally match the contract address. Accounting will not change the mailing address unless written notification is received by the Contractor directly, or by the County Treasurer's Office.

Field #3: Date. This date will either reflect the payment date as it was inputted into the CALSTARS system, or it will be blank.

Field #4: Vendor's No. or Invoice No. This is the identifying field of the funding. The Acronyms are attached for the Drug Medi-Cal and the Negotiated Net Amount contracts. This field will help identify the payments when the vendor calls. It is possible that multiple payments will appear on a RA, however, each will have it's own identifying numbers.

Field #5: Amount: The amount shown will only be for the period identified. Although multiple payments may be paid on one RA, each will be listed individually.

Field #6: Total amount of payment/RA: This will be the total of all items listed which add up to the total warrant.

ACRONYMS FOR DRUG MEDI-CAL PAYMENTS

Two types of payments are issued for the Drug Medi-Cal contracts. The first is the State General Fund (SGF) payment. Beginning in Fiscal Year 1998-99, only direct providers were required to submit Monthly Interim Payment Claims (MIPC) while the counties received each month 1/12 of their SGF DMC contract amount. These payments were issued separately by Regular (101) and Perinatal (102) funds as two funding sources are utilized.

The second type of payment is based on the Approved Services Report (ASR) which is received from the Department of Health Services (DHS). ASR payments were also issued separately by Regular (101) and Perinatal (102) funds. Payments that were issued by the ASR method did not necessarily tie to the total monthly claim submitted. Counties and providers must review their copy of the ASR, Error Correction Reports (ECR), and any other documentation received from ADP. The Accounting Office cannot identify the funding sources or amounts any further than is already identified on the RA.

A sample of the data that would be placed in the fields of the RA is as follows:

In Field #4 of RA	Identifies
05/96 101M/C-F	May 1996, Regular Medi-Cal, Federal Share
05/96 102M/C-F	May 1996, Perinatal Medi-Cal, Federal Share
10/97 101M/C-G	October 1997, Regular Medi-Cal, State General Share
10/97 102M/C-G	October 1997, Perinatal Medi-Cal, State General Share

The first 5 spaces indicate the month and year of service, followed by a space. The next three digits (numbers) indicate Regular (101) or Perinatal (102) funds. M/C means Medi-Cal, followed by a dash and the letter F or G. The letter F means Federal Share of funds and the letter G means State General Fund share.

ACRONYMS FOR NNA PAYMENTS

NNA (Negotiated Net Amount) payments are identified in Field # by the fiscal month and the grant or funding source.

01 – July
02 – August
03 – September
04 – October
05 – November
06 – December
07 – January
08 – February
09 – March
10 – April
11 – May
12 – June

93.959	Substance Abuse Prevention and Treatment (SAPT) Block Grant
84.186	Safe Drug Free Schools and Communities (SDFSC) Grant
GENFND	State General Fund (Fund 101)
PERI	Perinatal State General Fund (Fund 102)
CDC	California Department of Corrections

SERVICE CODES COMPARISON - FY 1997-98 and FY 1998-99

Service Code Descriptions	FY 1997-98 Code Number	FY 1998-99 Code Number
Support Services		
County Support	00	00
Quality Assurance	01	01
Training	02	02
Program Development	03	03
Research and Evaluation	04	04
Planning, Coordination, Need Assessment	05	05
Start Up Costs	06	06
Cost Efficiencies (Budgeting Purposes Only)	08	08
Facility Construction or Rehabilitation	09	09
Primary Prevention		
Other	11	11
Information Dissemination	12	12
Education	13	13
Alternatives	14	14
Problem Identification and Referral	15	15
Community-Based Process	16	16
Environmental	17	17
Secondary Prevention		
Early Intervention	18	18
Outreach/Intervention	19	19
IDU Outreach	20	20
Referrals/Screening/Intake	21	21
California Mentor Initiative	24	24
Nonresidential		
Rehabilitative/Ambulatory Intensive Outpatient (DCH)	30	30
Rehabilitative/Ambulatory Outpatient		
Aftercare	32	32
Outpatient Drug Free (ODF) Group	33	33
Outpatient Drug Free (ODF) Individual	34	34
Interim Treatment Services (CalWORKS Only)	35	35
Narcotic Treament		
Narcotic Replacement Therapy (NRT) - Methadone		
Outpatient Methadone Detox (OMD)	41	41
Inpatient Methadone Detox	42	42
Naltrexone	43	43
Rehabilitative/Ambulatory Detox (Other than Methadone)	44	44
NRT - LAAM		
NRT - Methadone/LAAM - Group Counseling		
NRT - Methadone/LAAM - Individual Counseling		
NRT - All Services	48	48
Residential		
Free-Standing Residential Detoxifcation	50	50
Residential/Recovery Long Term (over 30 days)	51	51
Residential/Recovery Short Term (up to 30 days)	52	52
Hospital Inpatient Detoxification (24 hour)	53	53
Hosptial Inpatient Residential (24 hour)	54	54
Chemical Dependency Recovery Hosptial (CDRH)	55	55
Transitional Living Center (Perinatal/Parolee Only)	56	56
Alcohol/Drug Free Housing	57	57
Ancillary Services		
Perinatal Outreach	22	22
Cooperative Projects	63	63
Vocational Rehabilitation	64	64
HIV Early Intervention Services	65	65
Tuberculosis Services	66	66
Interim Services (within 48 hours)	67	67
Case Management (Perinatal/Parolee Only)	68	68
Primary Medical Care (Perinatal Only)	69	69
Pediatric Medical Care (Perinatal Only)	70	70
Transportation (Parolee Only)	71	71
Driving Under the Influence		
Driving Under the Influence	90	90

Service Codes 40, 45, 46, and 47 for NTP services are for budgeting only.

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PROGRAM CODES COMPARISON- FY 1997-98 and FY 1998-99

Program Code Listing	FY 1997-98 Code Number	FY 1998-99 Code Number
NNA Alcohol/Drug	1	1
NNA Parolee	2	2
NNA Perinatal	3	3
NNA Alcohol/Drug - Other	4	4
NNA Alcohol/Drug - Other	5	5
NNA Alcohol/Drug - Other	6	6
NNA Alcohol/Drug - Other	7	7
NNA Parolee - Other	8	8
NNA Parolee - Other	9	9
NNA Perinatal - Other	10	10
NNA Perinatal - Other	11	11
NNA Mentor (In Need of Treatment)	12	12 (*)
NNA Mentor (Not In Need of Treatment)	13	13 (*)
NNA/DSS CalWORKs	14	14
NNA/DSS CalWORKs - Other	15	15
NNA/Drug Court - Alcohol/Drug	16	16
NNA/Drug Court - Perinatal	17	17
NNA/Drug Court Partnership - Alcohol/Drug		18
NNA/Drug Court Partnership - Perinatal		19
NNA Adolescent Treatment		20
D/MC-DSS CalWORKs - Non Perinatal	30	
D/MC-DSS CalWORKs - MC Non Perinatal	31	
D/MC-DSS CalWORKs - Perinatal	32	
D/MC-DSS CalWORKs - MC Perinatal	33	
D/MC EPSDT	90	90
D/MC EPSDT - Perinatal	91	91
D/MC Minor Consent	92	92
D/MC Minor Consent - Perinatal	93	93
D/MC Private Pay	94	94
D/MC Perinatal	95	95
D/MC Perinatal - Other	96	96
D/MC Alcohol/Drug	97	97
D/MC Alcohol/Drug - Other	98	98
D/MC Alcohol/Drug - Other	99	99

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(*) Referenced in ADP Bulletin #99-02

FUNDING LINES COMPARISON- FY 1997-98 and FY 1998-99

Funding Description	FY 1997-98 Funding Line Number	FY 1998-99 Funding Line Number
Drug/Medi-Cal (Fed Share Only) - Fed. Cat. 93.778	40	40
Perinatal-Medi-Cal (Fed Share Only) - Fed. Cat. 93.778	40a	40a
Perinatal (PTEP) Match to Medi-Cal	40b	40b
DDS/CalWORKs D/MC (Fed Share Only)	40c	
DSS/CalWORKs Peri. Medi-Cal (Fed Share Only)	40d	
Perinatal State General Fund	41c	41c
DSS/CalWORKs SGF Peri D/MC Match	41d	
Perinatal Treatment Network Services - SGF		41g
Perinatal Substance Abuse Treatment - SGF		41h
Perinatal State General Fund - Backfill	41x	41x
Female Offender Trmt. Project - Fed. Cat. 93.959	45	45
Parolee Services Projects	46	46
SAPT - Discretionary - Fed. Cat. 93.959	50	50
Adolescent Treatment Services - Fed. Cat. 93.959		50a
HIV Set-Aside - Fed. Cat. 93.959	51	51
SAPT - Perinatal Set-Aside - Fed. Cat. 93.959	52	52
Homeless Project - Fed. Cat. 93.959	54	
SAPT Special Projects - Fed. Cat. 93.959	56	56
SAPT Discretionary One-Time - Fed. Cat. 93.959	56a	56a
SAPT Drug Courts - Fed. Cat. 93.959	56b	56b
SSI/DA/A Funds - Fed. Cat. 93.959	57	57
SSI/DA/A HIV Funds - Fed. Cat 93.959	57a	57a
DSS/CalWORKs SAPT	58	58
Private Industries Councils (PIC)	58a	58a
SDFSC School/Comm. Based Prevention - Fed. Cat. 84.186	62	62
SDFSC Friday Night Live - Fed. Cat. 84.186	66	66
SDFSC Club Live - Fed. Cat. 84.186	68	68
CA Mentor Initiative - Fed. Cat. 84.186	68a	68a
State General Fund - Match to Medi-Cal	70	70
TCM - MAA	79	79
Non County Revenue	80	80
State General Fund	80c	80c
DSS/CalWORKs SGF Non-Peri D/MC Match	80d	
DSS/CalWORKs SGF	80e	80e
State General Fund - Regular - Backfill	80x	80x
Required County Match - Alcohol/Drug or Perinatal	81c	81c
County Funds - Other	82	82
Provider Unrestricted Funds	82a	82a
County Unrestricted Funds	82b	82b
Excess Fees Spent	83	83
Fees	84	84
Insurance	85	85
SB 920/SB 921	86	86
Statham	87	87
Statham Match - Alcohol/Drug or Perinatal	87c	87c
Excess DUI Profit/Surplus Spent	88	88
Drinking Driver Fees & Admin. & Monit.	89	89
Penal Code (PC) 1000 (Admin. Fees)	89a	89a
Obligated Unexpended SGF Prior FY	90a	90a

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COMPUTER SPECIFICATIONS

- an IBM compatible personal computer with WINDOWS software version 3.1 (or higher);
- a mouse;
- an EGA monitor (or higher);
- a WINDOWS compatible printer; and
- a PARADOX Run Time 4.5 installation diskette.

FISCAL MANAGEMENT BRANCH
COUNTY AND TEAM LISTING

BOB MARTIN - FRANCINE MANAS 'TW'

02	ALPINE	NNA	Francine
07	CONTRA COSTA	DMC	Francine
08	DEL NORTE	NNA	Francine
16	KINGS	NNA	Bob M
27	MONTEREY	DMC	Francine
37	SAN DIEGO	DMC	Bob M
	SDTS #8776, #8777	DMC	Bob M
	SDHA #8778, #8779, #8780	DMC	Francine
45	SHASTA	DMC	Bob M
49	SONOMA	DMC	Francine
54	TULARE	DMC	Francine
55	TUOLUMNE	NNA	Bob M
57	YOLO	DMC	Bob M
58	SUTTER/YUBA	DMC	Bob M

JEAN ANDERSON - VIVIAN ROBERTS 'SW'

04	BUTTE	DMC	Vivian
	EAP#0434	DMC	Vivian
	CHP#0499 / AEGIS#0498	DMC	Vivian
10	FRESNO	DMC	Jean A
38	SAN FRANCISCO	DMC	Vivian
40	CHP#4002 / AEGIS#4003	DMC	Jean A
50	CHP#5021 / AEGIS#5008	DMC	Jean A
58	CHP#5899 / AEGIS#5820	DMC	Jean A

LAURA ELJAIEK - RAE FINKE - TRACEY JAMES 'TW'

01	ALAMEDA	DMC	Tracey
	#0121,#8106,#8107	DMC	Tracey
06	COLUSA	NNA	Laura
13	IMPERIAL	DMC	Laura
	IV#1308	DMC	Laura
20	MADERA	DMC	Laura
26	MONO	NNA	Tracey
28	NAPA	DMC	Rae
29	NEVADA	DMC	Rae
32	PLUMAS	NNA	Rae
34	SACRAMENTO	DMC	Laura
44	SANTA CRUZ	DMC	Laura
50	STANISLAUS	DMC	Rae
56	VENTURA	DMC	Tracey

SANDRA CORTI - FATIMA AZIZ 'SW'

12	HUMBOLDT	DMC	Fatima
14	INYO	NNA	Sandra
19	LOS ANGELES	DMC	Sandra
22	MARIPOSA	NNA	Fatima
31	PLACER	DMC	Fatima
41	SAN MATEO	DMC	Fatima
42	SANTA BARBARA	DMC	Fatima
46	SIERRA	NNA	Fatima
52	TEHAMA	NNA	Fatima

PAM HASS - BARBARA NORTON 'TW'

05	CALAVERAS	NNA	Pam
18	LASSEN	NNA	Pam
23	MENDOCINO	DMC	Barbara
30	ORANGE	DMC	Pam
	CTS#3097	DMC	Barbara
	WP#3098,#3099	DMC	Barbara
39	SAN JOAQUIN	DMC	Pam
47	SISKIYOU	NNA	Barbara
53	TRINITY	NNA	Barbara

JULIAN PEREZ - MIKE GOMEZ 'SW'

03	AMADOR	NNA	Julian
09	EL DORADO	DMC	Julian
11	GLENN	NNA	Mike
15	KERN	DMC	Mike
17	LAKE	DMC	Mike
21	MARIN	DMC	Julian
24	MERCED	DMC	Julian
25	MODOC	NNA	Mike
33	RIVERSIDE	DMC	Julian
35	SAN BENITO	NNA	Julian
36	SAN BERNARDINO	DMC	Mike
40	SAN LUIS OBISPO	DMC	Mike
43	SANTA CLARA	DMC	Julian
48	SOLANO	DMC	Mike

ANQUNETT FAZIL 'SW'

QUILLING 'v' BELSHE' CLAIMS

TELEPHONE NUMBERS FOR:	"916"
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Fatima Aziz	322-1247
Sandra Corti	323-2047
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Anqunett Fazil	327-4871
Rae Finke	445-0643
Michael Gomez	323-1819
Pam Hass	323-4788
Tracey James	327-9501
Francine Manas	327-8614
Bob Martin	445-1170
Barbara Norton	323-2019
Julian Perez	323-2502
Vivian Roberts	323-2035

SW - Susan Wilson, Acting Manager "916" 323-6698
TW - Terrie Williams, Supervisor "916" 323-2058

ADP BULLETIN

Title		Issue Date: 08-17-98 Expiration Date: When Superseded	Issue No. 98-42
Fiscal/Audit Questions and Answers			
Deputy Director Approval DESIRÉE WILSON Deputy Director Division of Administration	Function [ ]Information Management [ ]Quality Assurance [ ]Service Delivery [X]Fiscal [ ]Administration	Supersedes Bulletin/ADP Letter No. N/A.	

PURPOSE

This Bulletin is to convey information regarding various fiscal/audit issues.

DISCUSSION

ADP Audit Services Branch staff were recently requested to respond to pre-developed questions in a presentation to California Association of Addiction Recovery Resources (CAARR). The following questions Nos. 1 - 13, reflect those questions and the answers provided during the presentation. In addition, question Nos. 14 and 15 were asked during the presentation, and a more complete answer is contained in this Bulletin. Question Nos. 16 and 17 were issues that have been brought to our attention through other channels.

1. What are the various types of contracts that are utilized by counties for fee-for-service, cost reimbursement, etc.?

Answer:

We would first like to confirm that there is an understanding of the terms mentioned in the question, in relation to Health and Safety Code (H&S) requirements. The H&S Code contains two parallel sections which deal with how counties may pay providers for services; 11818(b) for alcohol programs and 11987.5(a) for drug programs. Both sections state, in part, “The counties may enter into contracts with providers at actual cost or a negotiated rate.”

Actual Cost Contracts

An actual cost contract with a provider, from the State's perspective, is simply one that requires settlement of the contract in a manner which limits reimbursement to the provider's actual cost of providing services, or the contract maximum, whichever is less. Typically, counties will negotiate an expected level of service, which a provider must meet in order to receive full reimbursement of costs. This ensures that the county is not funding empty beds/slots.

The mechanisms for payment of funds during the contract are generally at the discretion of the county. A county may choose to pay one-twelfth of a 12-month contract budget each month. Or, a county could require invoices which reflect actual costs for each month. Any overpayment or underpayment is collected or paid when the year-end cost report is settled.

Negotiated Rate Contracts

These are sometimes referred to as fee-for-service contracts. We generally limit our use of the latter term to non-AOD Medi-Cal services to avoid confusion. According to the H&S Code, a negotiated rate is a "...specific and fixed dollar rate for a specified unit of service provided." Rates "... shall be based upon the projected cost of providing the services and projected revenues realized as a result of providing services." To justify these projections, "...The provider shall make available to the county information on prior years' actual cost of providing services and actual revenues."

The mechanism for payment of funds during the contract normally requires an invoice from the provider which identifies the number of units of service provided for the month.

There are some limitations to receiving full reimbursement of a negotiated rate, which are described in recent ADP letters/bulletins. In fact, two are just going out this week. The limitation that applies to residential programs involves the use of Federal SAPT Block Grant funds in the provider's contract. If an audit of such a negotiated rate contract is performed, it is possible that cost disallowances could still be assessed. The main reason would be to ensure that costs fully reimbursed by the rate do not include items which are unallowable in accordance with SAPT Block Grant requirements.

The limitation that affects other service modalities is where the funding mix includes Drug Medi-Cal dollars. In this event, negotiated rates "...shall be treated as provisional rates, subject to year-end settlement to actual costs."

Additionally, if an audit reveals that a rate was either too low to cover costs or excessively high, so as to provide revenue in excess of cost, a recommendation is made to adjust the rate to an appropriate level for future periods.

Drug Medi-Cal

In relation to the above two methods of reimbursement, Drug Medi-Cal providers are reimbursed in a slightly different manner pursuant to Title 22, CCR, Section 51616.1. With the exception of NTP providers, payment is made during the contract via a provisional rate. The only limitation on the provisional rate is that it cannot exceed the maximum allowance (often referred to as a rate cap). Interim settlement of a year-end cost report limits reimbursement to the lower of actual allowable costs or the maximum allowance. To the "entitlement" nature of D/MC, providers should not be limited by a contract amount.

However, if an audit is performed by ADP, an additional limitation on reimbursement will be considered, as required in Section 51616.1. This is the provider's usual and customary charge to the general public for the same or similar services. Medi-Cal will not reimburse more than this charge for services.

NTP providers are paid at fixed rates established in Section 51616.1, and are not subject settlement to actual costs. They are, however, limited to the lower of the fixed rate or the usual and customary charge to private patients.

2. What are NNA contract counties? How does this differ from counties with NNA agreements? What are the advantages and disadvantages of NNA contract counties?

Answer:

Providers must understand that Negotiated Net Amount (NNA) contracts are only for use between ADP and the counties. The premise is the negotiation of a bottom line total reimbursement for the county to receive for making available an agreed upon dedicated capacity. Contracts between counties and providers must meet the requirements discussed in Question No. 1.

Since FY 1994-95, every county has an NNA contract with ADP. We refer to the document as a contract, rather than an agreement. Consideration of advantages and disadvantages depends on your perspective. From an county's perspective, the main advantage of the NNA mechanism is that it allows a county to retain unused State General Fund (SGF) monies, which previously would have been returned to the State.

From an audit standpoint, the main disadvantage is that the unit of service definitions for NNA are different than for D/MC. This creates problems for the providers and auditors in that it necessitates conversion to some common basis for cost allocation purposes.

3. What are the state's procedures in auditing providers?

Answer:

We ensure audits are properly completed pursuant to OMB Circular A-133 for all providers who fall under this requirement. We review all reports and ensure adequate follow-up occurs.

In regard to our audit work, we cannot provide a comprehensive answer to this question, since much of our work is somewhat flexible and tailored to the specific circumstances and conditions found in the audit. In general, we can offer the following:

♢ We build on audit work already performed, to the extent that work is found to be acceptable to meet our audit objectives.

♢ We reconcile the county's cost report submitted to ADP to the provider's cost report.

♢ We reconcile the provider's cost report to the provider's financial records.

♢ We review recorded costs for allowability.

♢ We test revenues to ensure that all revenue required to be reported was reported on the cost report.

4. How often are audits required?

Answer:

OMB Circular A-133 audits are required annually, in most cases, for those providers required to have them.

ADP's audits are required more frequently than we are able to perform them. Also, requirements for alcohol programs differ from requirements for drug programs. For alcohol programs, H&S Section 11817.8 requires ADP to "...annually audit the expenditures of any organization funded, in whole or in part, with funds administered by the department." For drug programs, H&S Section 11991.6 requires ADP to "...audit or contract to audit the expenditures of counties and direct contractors at least every three years, including a sample of subcontractors funded in whole or in part with funds administered by the department." Any clean-up legislation which ADP has input into will correct these inconsistencies and align the requirements with practical capability.

Today, there are many programs we have never audited, and we use this fact along with certain risk factors to select programs for audit. County cost reports and claim information provide most of our risk factors. In addition, we receive referrals from various sources to audit certain programs. At this time, most of our focus is on D/MC providers.

5. What areas do they put the most importance on?

Answer:

In relation to residential programs, most of our emphasis tends to be on determining allowable costs, including reviewing cost allocation methodologies for multi-program providers. Another major consideration is where negotiated rates have been used, how they have been set. We would want to see that actual historical cost and revenue were used to establish the rate, and that the costs did not include unallowable costs or a profit component.

In relation to D/MC programs, a critical test is to determine the provider's customary charge to the general public for comparison to the D/MC cost per unit.

6. What are the leading audit exceptions when the state audits a program?

Answer:

As you can see in our internal article called "What Are Audit Findings?," (Exhibit 1 enclosed) most of our common findings involve D/MC. However, one of the issues we need to deal with for residential is the provision of D/MC outpatient services to clients of a residential program. This may, with the exception of sober living centers, represent a duplication of treatment billings. Refer to ADP #96-09 and #96-27.

7. What types of documentation are required to back up expenditures?

Answer:

First, a provider should have a formal set of financial records. This includes a general ledger, as well as books of original entry; cash receipts journal (register), cash disbursements journal (register), general journal. Entries in the books of original entry must be traceable to source documentation. Evidence of expenditure must be sufficient to substantiate that the expenditure was incurred and that the expenditure was necessary to the provision of service. This evidence would include paid invoices, canceled checks, contracts, purchase orders, receiving reports, etc.

8. What type of documentation must a program have to back up cost distribution (more than one contract)?

Answer:

A cost allocation plan should be maintained. This plan provides the allocation methodology and the statistical basis (or bases) upon which the allocation of various costs is computed. An audit should be able to test cost allocations to confirm that the plan was actually used.

Providers with several types of residential programs, such as detoxification, residential treatment, and transitional living centers, must realize that the cost per client-day is driven by the level of service provided. In other words, the amount of staff time required to carry out each program becomes a critical factor for allocation purposes. This is particularly important to recognize in situations where the same staff work in multiple programs. Some systematic accumulation of staff time then becomes a necessity. If programs are separately located, with separate staff, and separate cost accounts, there is no issue of shared direct costs, but some reasonable allocation process for indirect costs (administrative overhead) is still necessary. Also, counties and providers must be cognizant of the fact that the cost attributable to any residential program which does not provide treatment must not be funded with SAPT Block Grant funds.

9. What are the "bibles" for allowed and disallowed expenditures?

Answer:

SAPT Block Grant and SGF

Residential programs are likely to receive some combination of SAPT Block Grant and SGF. Generally, the SAPT Block Grant defers to the State's procedures for expenditure of its own funds. These would be found in the H&S Code, primarily Sections 11818 and 11991.2, in Title 9, CCR, Section 9424, and in the State-County contract. These State laws and regulations are vague and general, making reference to costs which are "necessary to the provision of service". Consequently, when questions arise, we sometimes refer to OMB circulars for answers regarding cost principles. OMB Circular A-122 provides the guidance for non-profit organizations.

In addition, there are a few specific restrictions attached to the SAPT Block Grant, which can be found in 42 USC 300-x, 45 CFR, Part 96, and in the Grant Award. These restrictions are as follows:

♢ Pay the salary of an individual at a rate in excess of $125,000 per year.

♢ Provide inpatient hospital services, with some exceptions related to medically necessary hospital-based substance abuse services, as defined under 45 CFR 96.135(c).

♢ Make cash payments to recipients of health services.

♢ Purchase or improve land, purchase construct, or permanently improve (other than minor remodeling) any building or facility, or purchase major medical equipment, unless a waiver is approved in accordance with 45 CFR 96.135(d).

♢ Satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds.

♢ Provide financial assistance to any entity other than a public or nonprofit private entity.

♢ Provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs, unless the Surgeon General of the Public Health Services determines that a demonstration needle exchange program would be effective in reducing drug abuse and the risk that the public will become infected with the etiologic agent for AIDS.

Refer to ADP Bulletin #98-16, Federal Block Grant Expenditure Restrictions, for more detail.

Drug Medi-Cal

If a program has mixed funding which includes D/MC, then settlement is to actual costs in accordance with Medi-Cal cost principles. In this instance, negotiated rates become provisional, as opposed to fixed rates.

Most common references are Title 22, CCR, primarily Section 51616.1; HCFA-15, the Federal Medicare cost guidelines; and definitions of services covered under D/MC, as contained in the Utilization Control Plan (now being incorporated into Title 22) and Title 9 CCR licensing and certification standards.

10. Why do counties get copies of audit reports, and if there's a problem, why do the counties get a bill?

Answer:

The county is ADP's contractor. Any finding against a provider is actually a finding that the county has overpaid a provider, resulting in ADP overpaying the county due to incorrect cost report information. ADP recovers from the county, and the county's collection effort to recover from the provider is its own concern. However, many counties include a provision in their contracts that requires repayment by providers for audit adjustments. There may be instances where the county shares some responsibility, due to misleading statements to the provider or the use of contractual language which conflicts with laws and regulations. Such circumstances could affect the county's ability to recover funds from the provider. However, such deficiencies do not effect the State's ability to recover from the county, nor the Federal Government's ability to recover from the State.

11. When are CPA audits required?

Answer:

We will answer this briefly, and provide you a phone number for any further questions.

OMB Circular A-133 audits are required of any provider that expends Federal funding (excluding Medi-Cal) of $300,000 or more in a given fiscal year. The Circular explains the scope and possible scope limitations under certain circumstances.

H&S Code, Chapter 5, Section 38041, requires that any direct service contractors with the State who receive $25,000 or more in Federal and/or State funds have an audit in accordance with Government Auditing Standards. This applies to few if any service providers at this time, since most contracts are with the counties.

12. Are CPA audits required for entire program operation, or just those that relate to contract budgets?

Answer:

This is a somewhat technical question. An audit of an entire organization is referred to as a "single audit", while an audit of just one contract or one service modality is referred to as a "program-specific audit". Conditions which allow a program-specific audit in lieu of a single audit are identified in OMB Circular A-133. Generally, a single audit is required unless the provider expends Federal awards under only one (1) Federal program (excluding research and development). If this is the situation, and the Federal program's laws and regulations or grant agreements do not require a financial statement audit, then the provider may elect to have a program specific audit performed.

While your CPA should be familiar with the OMB Circular A-133 direction on this topic, you may direct immediate questions to Dave Mar at (916) 324-2193.

13. What are the procedures for appeal when a program disagrees with audit exceptions?

Answer:

Any ADP audit report which contains a financial finding or a recovery resulting from the final audit settlement, provides the process for filing an appeal and a general description of the resolution process. ADP has interagency agreements with the Department of General Services, Office of Administrative Hearings for all non-Medi-Cal audits. For Medi-Cal, there is an interagency agreement with Department of Health Services, Audit Appeals Bureau, to hold the hearings.

14. Since providers are being asked to expand capacity, how are they able to do this with reimbursement being limited to actual cost in most cases, and with limitations on construction?

Answer:

It is true that expenditures for purchase or construction of buildings are not allowable costs for SAPT Block Grant or SGF reimbursement. Health and Safety Code Sections 11818 (a) and 11991.2 state that reimbursement shall **not** be made for expenditures for **purchase** or

construction of buildings, except remodeling expenses as provided for in regulations, for expenditures for purposes for which state reimbursement is claimed under any other provision of law, or for expenditures pursuant to Section 11755.5.

However, ADP does have a general waiver of the SAPT prohibition, provided that a specific approval process is followed. Please contact your county for details on the process.

There are **other means** of recovering certain costs related to start-up or expansion, which are more commonly used, as itemized below.

Depreciation

Title 9, California Code of Regulations (CCR), Section 9424, Reimbursable Expenditures, includes "Depreciation of fixtures and equipment of county-operated programs and privately operated agencies as established in the Accounting Standards and Procedures for Counties, State of California, State Controller."

The term "fixtures" in the above section includes buildings purchased or constructed and major remodeling/renovation/additions which add value to property. Depreciation is the only allowable means of recovering such costs.

Minor Remodeling

On April 26, 1994, ADP and the U.S. Dept. of Health and Human Services (HHS), Office of Civil Rights, entered into a Voluntary Compliance Agreement (VCA). The VCA covers existing residential alcohol and other drug (AOD) service providers, that are under contract with the County and that are subrecipients of HHS financial assistance. These facilities were required to be accessible in their entirety to nonambulatory adults by December 31, 1995. When providers expand their operating capacity, minor remodeling costs associated with program accessibility can be recouped by using SAPT Block Grant funds. However, any proposed remodeling for a building cannot materially increase the value of the building or the total cost exceed $50,000 over a three-year period. (Refer to ADA Circular 94-04 for details on conditions and the requirements.) Other funding sources, such as ADA tax credit and tax deduction, are also listed in this circular.

Start-Up Costs

Providers, with the exception of NTP programs, are able to claim certain costs as "start-up costs." This is allowed under D/MC, in accordance with Provider Reimbursement Manual Section 2132. D/MC costs meeting the definition of start-up costs may be amortized over a 60-month period from the date of certification.

Provider Reimbursement Manual Section 2132.3, "Cost Treatment for Medicare Reimbursement", contains the following language:

> "Where a provider prepares all portions of its facility for patient care services at the same time and has capitalized start-up costs, the start-up costs must be amortized ratably over a period of 60 consecutive months beginning with the month in which the first patient is admitted for treatment. Where a provider prepares portions of its facility for patient care services on a piecemeal basis, start-up costs must be capitalized and amortized separately for the portions of the provider's facility that are prepared for patient care services during different periods of time. If a provider expands its facility by constructing or purchasing additional buildings or wings, start-up costs should be capitalized and amortized separately for these areas. Start-up costs that are incurred immediately before a provider enters the program and that are determined to be immaterial by the intermediary need not be capitalized, but rather, may be charged to operations in the first cost reporting period. In the case where a provider incurs start-up costs while in the program and these costs are determined to be immaterial by the intermediary, these costs need not be capitalized, but may be charged in the periods incurred."

Start-up costs are allowed for other funds based on department policy, as defined in ADP #89-27, "Reimbursement of Expenses Incurred Prior to Commencement of Services." This policy statement generally mirrors the Provider Reimbursement Manual, except that it further defines the terms "immediately before entering the program" and "immaterial". It states that the start-up costs that are incurred no more than 90 days before a provider furnishes service to the first client and that are determined by the Department to be immaterial need **not** be capitalized, but rather, may be charged to operation in the period incurred. As a general rule, the Department will consider start-up costs that do not exceed 15 percent of the provider's yearly reimbursable costs of operation to be immaterial. A County may advance such start-up costs to providers subject to the following conditions:

(1) The County determines that an advance payment is essential for the effective implementation of the program.

(2) Advances are made pursuant to a written contract with the provider which specifies those start-up activities to be reimbursed, requires commencement of program operations within 90 days, and otherwise meets applicable contract requirements. (Refer to Title 9 Section 9426.)

15. If a D/MC provider has clients who are funded by the Veteran's Administration (VA) benefits, are these clients considered private and their benefits used for purposes of determining the provider's usual and customary charge?

Answer:

Provider Reimbursement Manual (PRM) Section 2604.3 defines customary charges as those uniform charges listed in a provider's established charge schedule which is in effect and applied

consistently to most patients and recognized for program reimbursement. Where a provider does not have an established charge schedule in effect and applied to most patients, the determined customary charges' are the most frequent or typical charges imposed uniformly for given items or services. However, in either case, in order to be considered customary charges, they must actually be imposed uniformly on most patients and actually be collected from a substantial percentage of patients liable for payment on a charge basis.' Such charges must also be recognized for program reimbursement.

If a provider has a uniform charge listed in an established charge schedule in effect and applied consistently to most patients, and recognized for program reimbursement, then the listed charge is the customary charge for comparison to costs for reimbursement purposes irrespective of the presence of VA patients.

If a provider does not have an established charge schedule, but has a customary charge imposed uniformly on most patients, and non-VA patients comprise most of the non-Medi-Cal patients, then the charge imposed on those non-VA patients would be used in the lower of cost or charges calculation.

According to PRM Section 2604.3 B (1) (b), if VA patients comprise most of the non-Medi-Cal patients, and they are represented by a plan or agent under contract or agreement to make payment directly to the provider on a basis other than full charges, in other words, the provider receives payment directly from the VA in the name of the patients, then the VA patients would not be liable for payment on a charge basis, and thus these patients should not be considered for determining the provider's usual and customary charge for purpose of the lower of cost or charges reimbursement principle.

Please note that the conclusion reached by this analysis is contrary to the Congress's intent in enacting the lower of cost or charge reimbursement principle. The Congress intended the budgets of the Medicare and Medicaid programs not be increased by bearing some of the costs of non-program patients. This result will have the net effect of the Medicaid program bearing some of the costs of providing services to non-Medicaid, i.e., VA patients.

16. For a negotiated rate residential program, which allows a client a weekend leave from the program as part of a reward or incentive policy, must these days of absence be deducted for billing purposes?

Answer:

This depends primarily on the county/provider contract negotiation process. If this is a long-standing policy which is used fairly extensively, the county may wish to use actual historical **client-days attended** as a basis for determining the negotiated rate. If this is the case, the rate would be higher than a rate using enrolled client-days, and absences should be deducted.

However, if historical **enrolled client-days** are used in establishing the negotiated rate, the provider should be able to bill for all client-days of enrollment in the program. In other words, days for which a client is enrolled in the program, regardless of physical presence would be billable client-days, and no deduction for absences would be necessary.

From an auditing perspective, issues of materiality and the clarity of the negotiated rate development would have to be considered. Isolated instances of client absences and/or ambiguity regarding the statistical basis for establishing the negotiated rate would likely result in a management finding, as opposed to a financial finding.

17. For a residential program with a negotiated rate, are both a client's date of admission and date of discharge billable client-days?

Answer:

No. Payment for either the date of admission or the date of discharge may be made, but not both. An analogy would be a hotel customer being asked to pay for the day he/she checks in and the day he/she checks out. Counties should make this policy clear to their residential providers, preferably through contract language. This policy is found in the Alcohol Services Reporting System Manual for County Alcohol Programs (ASRS) Section IV, "Cost Guidelines and Reporting Units."

REFERENCES

42 USC 300-x.31
45 CFR Part 96 Block Grant
CCR Title 9. Rehabilitative and Developmental Services
CCR Title 22. California Medicaid Program
OMB Circular A-133 Audit of Institutions of Higher Education and Other Non-profit Institutions
OMB Circular A-122 Cost Principles for Non-profits
Health and Safety Code (H&S)
Provider Reimbursement Manual (HCFA 15)
Alcohol Services Reporting System Manual for County Alcohol Programs (ASRS)
ADA Circular 94-04 Funding Sources/Planning for Making Facilities Accessible to Nonambulatory Persons, December 27, 1994.

HISTORY

ADP Letters:

ADP Bulletin #98-16 Federal Block Grant Expenditure Restrictions
ADP #96-09 Certification of Drug/Medi-Cal Clinics, February 29, 1996

ADP #96-27 Enforcement of ADP #96-09, June 3, 1996.
ADP #89-27 Reimbursement of Expenses Incurred Prior to Commencement of Services, April 17, 1989.

QUESTIONS/MAINTENANCE

Any questions on the content of this bulletin should be directed to Andy Dill, Assistant Audit Manager, at (916) 324-6406 or Gary Bellamy, Audit Manager, at (916) 322-4834.

EXHIBITS

Article from Administrative Update Bulletin, dated October 6, 1997, "What Are Audit Findings?"

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STATE OF CALIFORNIA-HEALTH AND HUMAN SERVICES AGENCY GRAY DAVIS, *Governor*

DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS
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ADP BULLETIN

Title **Update to Audit Assistance Guide**		Issue Date: 5-19-99 Expiration Date:	Issue No. 99-17
Deputy Director Approval Ann Horn, Acting Deputy Director Division of Administration	Function [ ]Information Management [ ]Quality Assurance [ ]Service Delivery [X]Fiscal [ ]Administration	Supersedes Bulletin/ADP Letter No.	

PURPOSE

This bulletin is to provide an update to the Audit Assistance Guide (AAG), the last version of which was issued November 1, 1990. The AAG was issued primarily for the benefit of alcohol and drug treatment providers. It provided a basic framework for establishing an accounting system that facilitates compliance with funding source requirements. This guidance was provided to minimize the risk of audit exceptions.

DISCUSSION

The Department plans to review the AAG to evaluate the need for updates and revisions. As indicated in the Introduction, the AAG was not designed to contain the laws and regulations that apply to alcohol and drug programs. However, due to the mix and complexity of current funding requirements, any future updates/revisions to the AAG found to be necessary will provide statutory and regulatory references, as appropriate.

Appendix G of the AAG (the last appendix in the current version) does contain descriptions of some requirements and restrictions specific to determining allowability of costs. While the AAG has not been updated for changes in funding requirements and restrictions, the Department has provided such authoritative criteria references through a variety of written documents, sometimes followed up with regional training sessions. The primary means of communicating these requirements have been:

- County Plan Guidelines through FY 1993-94.
- Negotiated Net Amount and Drug Medi-Cal contracts beginning with FY 1994-95.
- ADP Letters and Bulletins explaining and clarifying the requirements.

The Audit Services Branch (ASB) has taken the opportunity to prepare a number of ADP Letters and Bulletins to discuss various fiscal issues from an audit perspective, as well as provide input for many other letters. These letters/bulletins have normally been issued when it is perceived that there are questions and misunderstandings, as well as when significant legislative changes occur. They have become the primary means of conveying relevant information to the field regarding issues that could have audit implications.

It has come to our attention that such information has not always reached its final user. Additionally, it is possible that not all final users may have organized the information in a way that allows for easy reference.

Therefore, we are proposing that all ADP bulletins identified as Fiscal and related to accounting for costs, allowability of costs, compliance issues which could result in financial disallowances, and general information regarding requirements and restrictions related to various types of funding be contained in an appendix of the AAG. The compilation of documents should be labeled Appendix H." Enclosed is a summary document of the relevant information contained in each letter/bulletin.

In compiling these documents, we have gone back as far as ADP #95-45, issued October 16, 1995, to accumulate relevant information to include in the AAG. Due to the extensive amount of paper necessary to provide hard copy documents, we are not able to enclose all of the referenced ADP letters and bulletins. However, we have ensured that all of the bulletins are available on the Internet at http://www.adp.cahwnet.gov. Future ADP Bulletins which should be added to Appendix H of the AAG will contain a suggestion to that effect.

REFERENCES

See Exhibits.

HISTORY

See Discussion section above.

QUESTIONS/MAINTENANCE

If you have questions regarding this bulletin, please contact Sima Mann at (916) 322-0862 or Mike Hori at (916) 445-5067. If you need a copy of the Audit Assistance Guide and/or are unable to access specific ADP letters/bulletins referenced in Appendix H, please contact your county representative or Renae Anub at (916) 327-6937 or Cynthia Amaya at (916) 445-7993.

EXHIBITS

Exhibit	Title
1	Summary of Appendix H to Audit Assistance Guide

DISTRIBUTION

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AUDIT ASSISTANCE GUIDE
SUMMARY OF APPENDIX H

ADP #95-45, October 16, 1995, Drug/Medi-Cal Billing Claim Guidelines, Fiscal Year 1995-96

In addition to claiming instructions, this letter explained the basic principles of cost allocation, as well as the impact of AB 911 on ODF reimbursement by Drug/Medi-Cal. Further, a definition of unrestricted funds was provided, a definition which was ultimately redefined in ADP Bulletin #98-18. ADP Bulletin #98-18 partially superseded ADP #95-45.

ADP #96-05

This letter provided a general description of the Lower of Cost or Charges (LCC) principle. Because it did not provide enough information for counties/providers to apply the principle, it was supplemented with ADP # 96-22.

ADP #96-22, April 17, 1996, Additional Information on the Lower of Costs or Charges Principle

This letter supplements and clarifies ADP #96-05, providing more information regarding how the LCC principle is applied. Additional information on this topic is presented in ADP #97-38, as related to Narcotic Treatment Programs under AB 2071.

ADP #96-27, June 3, 1996, Enforcement of ADP #96-09

This letter discussed how the Department would enforce the restrictions specified in ADP #96-09, which prohibited outpatient D/MC clinic certification for services to certain residential treatment clients.

ADP #96-31, June 18, 1996, OMB Circular A-133 Reminder Letter, FY 1994-95

This letter, in addition to reminding counties of the A-133 audit requirement, transmitted the most comprehensive listing of Federal requirements which ADP has made available. A compliance supplement was promised for the next year s reminder, which would provide specific guidance to auditors in testing for compliance with the requirements. The letter was only sent to the county administrators and direct service contractors.

It is noteworthy that the information contained in this document was prior to AB 2071, which changed the D/MC reimbursement process for Narcotic Treatment Programs.

Additionally, it should be noted that for those programs to which the requirements continue to apply, the D/MC threshold for defining a capital expenditure (i.e. equipment) has changed from $500 to $5,000 per item. This will require a change to Title 9, CCR, Section 9440 to implement this change at the state level.

Another change is in the monetary threshold above which an OMB Circular A-133 audit is required. At the time ADP #96-31 was written, receipt of $250,000 or more in Federal awards required an A-133 audit. At this time, the threshold is $300,000.

ADP #96-64, December 27, 1996, Prohibition of Profit on Federal Grants

This letter proclaimed the prohibition of profit on the SAPT Block Grant, referencing ambiguous and conflicting language in the Health and Safety Code. While legal analysis supported this position, intent of the legislation was the ultimate factor in reversing this position in ADP #97-66.

ADP #96-66, December 31, 1996, Allowable Funding Sources for Drug/Medi-Cal Costs

This letter described the funding sources which could be used to fund various services to D/MC beneficiaries. It provided a narrow definition of unrestricted funds , as not including State General Fund (SGF) or county matching funds.

ADP #97-24, April 25, 1997, OMB Circular A-133 Reminder Letter

This was another reminder letter for submission of OMB Circular A-133 audit reports. It did not contain the auditing compliance tests mentioned in the previous reminder letter. This was due to statements made by OMB that a detailed compliance supplement was to be issued by that agency.

ADP #97-26, April 25, 1997, Clarification of ADP 96-64

This was a question and answer letter to discuss ADP #96-64 in greater detail. These answers were modified in ADP #98-17.

ADP #97-38, June 25, 1997, Private Charge Structure Information For NTP Providers--Audit Bulletin

This letter detailed how the Lower of Cost or Charges requirement would now be applied under the AB 2071 system. This was augmented with a training session and discussion forum with NTP providers.

ADP #97-39, June 27, 1997, Narcotic Treatment Programs--Audit Bulletin

This letter provided a list of fiscal issues that NTP audits would continue to address under AB 2071. Specific consequences/actions were tied to the specific deficiencies.

ADP #97-66, November 25, 1997, Modification of ADP #96-64, Federal Grant Profit

This letter was a retraction of ADP #96-64 regarding the prohibition of profit on the SAPT Block Grant. This letter promised a subsequent letter to provide details of SAPT Block Grant fiscal restrictions.

ADP Bulletin #98-16, April 9, 1998, Federal Block Grant Expenditure Restrictions

This bulletin provided a description of the SAPT Block Grant fiscal restrictions promised in ADP #97-66. It discusses how allowability of costs will be considered under negotiated rate contracts. It also makes it clear that the building of profit into a negotiated rate is inappropriate.

ADP Bulletin #98-17, April 9, 1998, Profit on Federal Grants

This bulletin was to clarify, update, and modify answers provided in ADP #97-26 in regards to profit on SAPT Block Grant.

ADP Bulletin #98-18, April 9, 1998, Cost Allocation and Drug/Medi-Cal Reimbursement

This bulletin updated and superseded portions of ADP #95-45 and modified portions of ADP #96-66. State General Funds (and county matching funds) were added to the definition of unrestricted funds available to cover D/MC costs in excess of the D/MC maximum allowance (rate cap).

ADP Bulletin #98-31, June 18, 1998, Annual OMB Circular A-133 Reminder Letter for FY 1996-97

This was another reminder bulletin for submission of OMB Circular A-133 audit reports. At this time, the OMB compliance supplement was still awaited. However, when subsequently received, the detail for alcohol and drug services was missing.

ADP Bulletin #98-42, August 17, 1998, Fiscal/Audit Questions and Answers

This bulletin answered questions raised by the California Association of Addiction Recovery Resources (CAARR). Generally, the questions and answers provide the audit perspective on allowability and support for costs reimbursed with SAPT Block Grant and SGF, with an emphasis on residential treatment. Some DMC considerations are also mentioned. The bulletin does not deal with NTPs under AB 2071, which are no longer part of a cost-reimbursement or negotiated rate system.

NOTE: Enclosure AJ to ADP Bulletin 99-30, dated 8-26-99:
please contact the Department of Alcohol and Drug Programs for a copy.
Thank you.

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Enclosure AK to ADP Bulletin 99-30, dated 8-26-99:
please contact the Department of Alcohol and Drug Programs for a copy.
Thank you.

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Enclosure AL to ADP Bulletin 99-30, dated 8-26-99:
Please contact the Department of Alcohol and Drug Programs for a copy.
This Enclosure is a letter from the California Department of Social Services.
Thank you.

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FOLLOW-UP ISSUES
IDENTIFIED IN
FY 1998-99 COST REPORT TRAINING SESSIONS

FUNDING ISSUES

- Funding Line 41g – Perinatal Treatment Network Services State General Fund = Can these funds be used under "County Support" to reflect county administration costs associated with this funding?

  No, Perinatal Treatment Network Services State General Funds cannot be used under "County Support" to reflect county administration costs associated with this funding. This funding is only allowed under outpatient drug free and residential services.

- Funding Line 50a - Adolescent Treatment Services = Is this funding allowed in services other than non-residential or residential?

  Yes, Adolescent Treatment Services funds are allowable in all services except Primary Prevention and Driving Under the Influence. [Ref. ADP Bulletin #99-06, dated February 2, 1999]

- Funding line 50a – Adolescent Treatment Services = Is there a maximum amount allowed under County Support?

  There is not a maximum identified for County Support. Since SAPT (Block Grant) funds are used for the Adolescent Treatment Services, the same guidelines for SAPT funds apply for Funding Line 50a.

- Funding line 41h – Perinatal Substance Abuse Treatment State General Fund = If this funding was used for start-up costs within a program, should it be reported under "County support" or under the cost of the program?

  Start-up costs that are incurred no more than 90 days before a provider furnishes service to the first client and that are determined by the Department to be immaterial need not be capitalized, but rather, may be charged to operation in the period incurred. As a general rule, the Department will consider start-up costs that do not exceed 15 percent of the provider's yearly reimbursable costs of operation to be immaterial. [Ref. ADP bulletin DDP #89-27]

COMPUTER ISSUES

- What version of the Paradox Diskette will be issued?

  The Paradox Runtime 4.5 version will be issued for reporting FY 1998-99 cost report expenditures.

- Is the Paradox Runtime 4.5 version compatible to Microsoft NT?

  Yes, Microsoft NT should be compatible with the Paradox Runtime 4.5 version as well as any Windows 3.1 or later software. If you have any questions or problems with loading the Paradox diskette, please contact Yue Kang at (916) 323-0519.

- Can the Paradox Runtime 4.5 version be programmed to allow for printing of either 'Portrait' or 'Landscape' at a personal computer's individual printer or a network printer without having to change print settings?

  Unfortunately not. The Paradox Runtime 4.5 is an older version and in order to print from a personal or a network computer printer, the print setting has to be changed between 'Portrait' and 'Landscape'.

MISCELLANEOUS ISSUES

- Will the Department send out a current telephone directory of ADP staff.

  A telephone directory of ADP staff is enclosed and is identified as Enclosure AK.

- What is the purpose of the "certification language" on the County Certification form (ADP 17885 – Enclosure A)?

  Please refer to the FY 1998-99 county contract, Section C, (b) which relates to Health & Safety Code, Section 11758.46 (h) (2) which states," A county or a provider, shall submit accurate and complete cost reports for the previous state fiscal year by November 1, following the end of the state fiscal year…"

- Can the data identified on the DHS generated reports (Approved Services Reports and Denied Reports) be separated by individual Service Function Code and not the range of the Service Function Codes?

  Unfortunately at this time, the DHS reports cannot be generated by individual service function codes. This issue will be reviewed in the future to determine the steps necessary to generate the reports by individual services function code rather than the range of service function codes.

- What is the e-mail addresses for Fiscal Management Branch staff?

  The e-mail address for any FMB staff or any ADP staff is the following:

  First initial of first name
  Entire last name
  @adp.state.CA.US

  Examples: Susan Wilson = swilson@adp.CA.US
  Vivian Roberts = vroberts@adp.CA.US

  The names if FMB staffs are identified in Enclosure AG while the names of ADP staffs are identified on Enclosure.

- Why doesn't the Allocation Report generated from the Paradox diskette match the County Final Allocation?

  When the Paradox diskette for the cost report is issued, the allocation information is reviewed to ensure the final allocation amounts are identified on the Paradox diskette. Sometimes allocation changes take place after the cost report Paradox diskette is issued; therefore, the report generated from the Paradox diskette is not accurate. However, after receipt of the cost report, the allocation amount identified on the Paradox diskette is compared to the final allocation issued by the Department to ensure that they are the same.

  If a county determines that their final allocation does not match the Allocation Report that is generated from the Paradox diskette, please contact your FMB analyst.

- On the County Worksheets (Enclosure C), can formulas be generated so the sub-totals of the various modality pages be forwarded to the Summary pages?

  Due to timing, this change will not be available for FY 1998-99 cost reports; however, it will be reviewed for implementation in the FY 1999-00 cost reports.

- Are Counties required to submit the Quarterly Utilization Report.

  Yes, counties are still required to submit the Quarterly Utilization Report. The information submitted on the Quarterly Utilization Report is required by the Federal Government to monitor the Federal funds given to the counties.

- Why is that more than one contract amendment required each year?

  One of the primary reasons of more than one contract amendments during a fiscal year is based on the Budget Allocation Act, which required the counties to reflect carryover Federal or State dollars in the final amendment. Another reason is based on new funding. Depending on the type of funding and management decision by ADP will depend if the counties have an option of submitting a contract amendment during the fiscal year.

- For the error message generated that identifies which specific funding line is over allocation, can the amount that is over be identified on the error message report?

  Due to timing, this change will not be available for FY 1998-99 cost reports; however, it will be reviewed for implementation in the FY 1999-00 cost reports.

- What is ADP's WEB site address?

  The Department's WEB site address is www.adp.cahwnet.gov/**.**

- For form ADP 7990 (Drug Medi-Cal Program Cost Summary), please identify the difference between lines 04a, 04b, and 04c (DMC Reconciliation of Claims) with Lines 05, 05a, 05b, and 05c (DMC Units of services)?

  The unit information in Lines 04a, 04b, and 04c is identifying the reconciliation of claims for the year, i.e., total claims submitted, denied claims, adjusted/erroneous claims and final adjusted claims. The unit information in Line 05 is the final adjusted claim amount identified from line 04c, Column 4. The amounts in 05a, 05b, and 05c is break out by reporting period of the unit amount shown on Line 05.

- Will ADP be issuing a letter to all counties regarding fiscal issues related to Cal-WORKS?

  No, ADP will not be issuing a letter regarding fiscal issues related to Cal-WORKS .

- What are the percentage requirements for Statham funds?

  A minimum of 33 percent of the funds shall be allocated to primary prevention programs in the schools and the community. These funds shall supplement and not supplant any local funds made available to support the county's alcohol and drug abuse education and prevention efforts.

- Did DSS Allocate separately Cal-WORKS SAPT/SGF fund?

  Please refer to the bulletin #98/99-33 from the Department of Social Service dated September 16, 1998 (Enclosure AL). This bulletin was mailed to all county welfare fiscal officers and all county welfare directors.

- Please provide cost report time table and explain the purpose of submitting cost report by November 1 of each year?

  Please refer Article V. Invoice/Claim and Payment Procedure in your FY 98/99 DMC contract. As for the purpose of submitting cost report by November 1, ADP shall determine actual costs upon which the rate of reimbursement will be recalculated. Then ADP will adjust subsequent reimbursements to the County to actual allowable costs.

CORRECTIONS

Some minor corrections on the cost report forms have been identified. Since they are minor, a new Cost Report Forms Diskette will not be issued. The minor corrections are:

- Enclosure C – Form ADP 7885C – Support Services = Changed "Ancillary Unit" to "Miscellaneous Unit" and changed "Service Code 12" to "Program Code 12".

- Enclosure C – Form ADP 7885E – Secondary Prevention Services = Changed "Ancillary Unit" next to Miscellaneous Unit and added "(Service Code 24)".

- Enclosure C – Form ADP 7885F – Nonresidential Services = Changed "Ancillary Unit" to "Miscellaneous Unit" for all three lines. Also, the Miscellaneous Unit term "Number of People" has been changed to "Number of Group Visits".

- Enclosure C – Form ADP 7885G – Narcotics Treatment = Changed "Ancillary Unit" to "Miscellaneous Unit" for all six lines.

- Enclosure C – Instructions (Page 1) = Changed "Ancillary Units" to "Miscellaneous Unit".

- Enclosure N – Form ADP 7990 = Above Columns 1 through 3 for Lines 05 through 05c, added title "Total Adjusted Units".

- Enclosure W – Summary of Cost Report Documents = Under Paradox Diskette added “Printout of all Reports (Year End Claim for Reimbursement, Fiscal Detail Report by Modality, Prevention/Treatment Summary Report, County Allocation Report, and Error Message Report.)”

  This is being added due to unanticipated but possible problems with respect to Y2K. This will allow ADP to continue processing and settling cost reports if the automated cost report system is not available.

- Enclosure AB – Program Code Comparison between FY 1997-98, and FY 1998-99 = Changed title ”Program Code Descriptions” to “Program Code Listing.” Added “NNA” to Adolescent Treatment line (Program Code 20).

- Enclosure J – Cost Report Funding Application Worksheet – ODF Group = Under the DMC column, the funding lines 41c and 80c were opened.

- Enclosure K – Cost Report Funding Application Worksheet – ODF Individual = Under the DMC column, the funding lines 41c and 80c were opened.

- Enclosure L – Cost Report Funding Application Worksheet – DCH = Under the DMC column, the funding lines 41c and 80c were opened.

Filename: G:\GROUPS3\FM\COST8-9\follow-up issues.doc; August 18, 1999